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THE ROLE OF CORRECTIVE THERAPY IN A TOTAL REHABILITATION PROGRAM

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The recent recognition of Physical Medicine and Medical Rehabilitation as a specialty in Medicine is, in the opinion of the writer, based on the growth of this field which has been enhanced by the technical development as well as by an urgent need for this phase of Medicine which supplements the therapeutic efforts of the internist, the surgeon, and the psychiatrist. Furthermore, by employing certain technical tests, Physical Medicine assists in many instances in establishing diagnoses and prognoses.

Any new field requires a definition of its mission, its scope, and its goal for the purpose of a clear understanding among those who practice this specialty and those who are reluctant to accept the services offered or are critical of the sincerity and value of the field. The therapeutic scope of Physical Medicine and Medical Rehabilitation lies in supplying facilities for early and complete physical, mental, social, and vocational rehabilitation. For this purpose the Veterans Administration has established a Physical Medicine Rehabilitation Service which offers corrective, educational, manual arts, occupational, and physical therapy.

The aim of this paper is to illuminate the contribution of corrective therapy and its relationship to other phases in Medical Rehabilitation. The corrective therapist is the professional successor of the medical gymnast of yesteryear who often was a layman without proper training and professional knowledge. The corrective therapist of today, however, is a college graduate who during his undergradute studies in physical education has acquired a background in basic sciences, such as anatomy, physiology, and kinesiology, and who is trained—either by postgraduate studies or special courses—in the technical skill and the scientific application of his therapeutic field. In addition this education should include, or be supplemented by, at least one course of clinical practice in therapeutic exercises applied to patients under the prescription of a physician. He, therefore, can academically take his place next to the physical therapist, the nurse, the social worker, and the members of the other ancillary services.

In contrast to physical therapy, which employs exercises for the purpose of obtaining recovery of diseased and disabled parts of the patient, the corrective therapy department approaches the medically prescribed therapeutic exercise program from a different point of view. In the first place, these exercises are directed towards the parts of the patient not involved in his disability and are designed to maintain tone and function of such parts; secondly, permanently disabled parts in which anatomical recovery is not expected are treated to obtain a maximal functional improvement. Generally, one may say that the goal of corrective therapy is the adjustment of the patient to his disability so that he learns to lead an adequate, enjoyable life in spite of his disability.

Because of the scope of this program the indications for corrective therapy are manifold. From the above stated remarks it is obvious, at least to those who are familiar with the Physical Medicine and Rehabilitation activities, that corrective therapy is a field whose duties and responsibilities are well defined; however, a brief discussion of some of those conditions which present themselves in a hospital rehabilitation service may help to illustrate the corrective therapy program and place it in its proper relationship to other forms of Physical Medicine as practiced at our hospital.

The arthritic patient receives a general conditioning exercise regimen for maintenance of function of muscles and non-involved joints from the corrective therapy department, thus supplementing the therapeutic procedures of the physical therapy department which are directed toward the restoration of function of the actively diseased joints. This exercise program may be given in the ward or in the corrective therapy clinic depending on the severity and acuteness of the disease. In addition, the corrective therapy department is directly responsible for the self-care training of the chronic arthritic invalid.

A similar cooperative therapeutic program is offered to the amputee. As overlapping of duties and efforts is carefully avoided by definition of the two fields as well as in practice, physical therapy treats the amputation stump and the remaining joints of extremity, while corrective therapy supplies—in addition to general conditioning exercises—ambulation training for the leg amputee.*

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* Presented to the New England Chapter of The Association for Physical and Mental Rehabilitation.

* Training of the arm amputee in the use of his prosthetic device is customarily entrusted to the occupational therapy department.

Although the clinical entity of low back strains is —as far as the Physical Medicine Rehabilitation Service is concerned—treated by the physical therapy department, instructions in posture and proper lifting, when indicated, may be given by the corrective therapist.

Especially in the early stages when recovery of function can be hoped for, treatment of the paralyzed extremities of the hemiplegic is strictly considered the responsibility of the physical therapy department. However, closely interwoven with this therapeutic endeavor is the corrective therapy regimen which consists of tonic exercises to non-paralyzed extremities, self-care training, and ambulation.

The paraplegic and the quadriplegic patient have long been a great challenge to any rehabilitation program. It is this writer's firm belief that only the efforts of a coordinated and cooperative program can lead to optimal results. Again, by definition the physical therapy department concerns itself with the treatment joint contractures, spasm, and paralysis and the Corrective erapy Department trains the patient—through its media: bed mat exercises, ambulation, gymnasium and mechanical devices—in are and locomotion; the latter includes wheel chair ambulation, h walking as well as driving specially equipped automobiles.

The poliomyelitic patient presents a similar problem which requires combined efforts. In the acute stage the patient is treated by the physical therapist, while in the convalescent stage a regimen similar to the paraplegic program requires the additional services of the corrective therapy department.

In addition to therapy given to patients with organic disabilities, the corrective therapy department cares for the psychiatric patient by providing exercises for the purpose of maintaining or developing physical stamina of the mentally sick and to observe his behavior in a group environment, to adjust him to group living and through individual treatment to supply socially acceptable outlets for his pathological behavior patterns.

Simultaneously and cooperatively interwoven with the corrective and physical therapeutic programs, the other Physical Medicine departments provide their share in the total rehabilitation effort. Kinetic occupational therapy is intimately connected with any exercise regimen designed to improve function; furthermore, occupational therapy provides another medium for tonic treatment either by itself for the patient who cannot take part in an exercise program, or in conjunction with corrective therapy; psychiatric occupational therapy, of course, augments the above described exercise therapy. The chief role played by the manual arts therapy department consists in its work endurance program, its training in sound shop habits and its methods of adjusting shop procedures to the needs of the handicapped. Educational therapy, as recently described[1], is applicable mainly to the intellectual rehabilitation except for certain types of patients, such as tuberculous, where it may serve as testing and training ground for work tolerance.

The proper definition of the field of exercise therapy makes it obvious that corrective therapy is an entity which is an essential part of the total rehabilitation program and which is neither in competition with nor a part or subdivision of, physical therapy or occupational therapy, the two generally recognized therapeutic specialties in Physical Medicine. On the contrary, corrective therapy has become a specialty which cooperates with, and augments, the endeavors of the other therapeutic departments. In our experience over a period of more than five years corrective therapy is indispensable in any rehabilitation program and constitutes by its definition a profession of its own.

The question whether corrective therapy is a profession has been answered by the corrective therapists themselves through their work performance and standards. In this writer's opinion the main distinction in any profession is its ability to go on record for the purpose of openly professing its work so that advantage may be taken by others of the contributions made, that results may be evaluated and methods improved, and that constructive criticism may help to eliminate errors.

During the past five years corrective therapy has gone on record in two ways. Many a good paper has been published by members of this profession. Moreover, recognizing that all cases treated by Physical Medicine are referred cases and that written statements constitute the main channel of informing the referring physician about the response of his patient to treatment, corrective therapy has developed a method of progress notes which in our hospital has proved to be efficient and essential for the psychiatric as well as for the general medical and surgical patient. An excellent system of writing such notes for the psychiatric patient has been designed by John E. Davis[2] and in our hospital the corrective therapists have initiated a similar system for general medical and surgical patients[3].

Most of the scientific publications have originated from the corrective therapy department of our hospital have dealt with the rehabilitation of paraplegics. Nevertheless many of the described methods are applicable to the rehabilitation of other types of disabilities. Such contributions as "Mobilization of Paraplegics" by Sanders[4] and the text on "Ambulation: Physical Rehabilitation for Crutch Walkers" by Dening, Deyoe and Ellison[5] deserve, and have received, recognition by the medical profession.

In conclusion, it may be summarized that corrective therapy is one of the fields of Physical Medicine

and Medical Rehabilitation which has a definite mission, which is augmenting, but in no way displacing, other forms of rehabilitation. Over a period of more than five years, corrective therapy has proved itself as a professional service acceptable and essential to the total rehabilitation program; it merits the recognition of the medical profession not only because of the great enthusiasm of the corrective therapists, but chiefly because of its contributions as a therapeutic field.

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MOBILIZATION OF THE ELBOW JOINT FOLLOWING INJURY OR DISEASE

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ANATOMY OF THE ELBOW JOINT: To properly understand the intricate function of the elbow joint, it is necessary to review the anatomy. The distal end of the humerus and the proximal end of the ulna and radius come together to form the elbow joint. The distal end of the humerus has four separate centers of ossification, one each for the trochlea, the capitellum, the lateral and medical epicondyles. The trochlea and the capitellum are formed by the distal end of the humerus, becoming flattened from before backwards, elongated laterally and medially, and curved slightly forward. These articular surfaces are divided into two parts by a ridge. The medial lateral epicondyles project on either side. The trochlea or medial articular portion occupies a slightly lower level than the lateral or capitellum. It is convex from before backwards, concave, from side to side, and occupies the anterior and posterior parts of the extremity. The lateral border separates it from the groove which articulates with the margin of the head of the radius. The medial border is thickened, of greater length and consequently more prominent than the lateral. The groove portion of the articular surface fits accurately with the semilunar notch of the ulna; above the front part of the trochlea is a small depression, the coronoid fossa, which receives the coronoid process of the ulna during flexion of the elbow. Above the back portion of the trochlea is a deep triangular depression, the olecranon fossa, in which the summit of the olecranon is received in extension of the elbow. These fossae are separated from each other by a thin transparent laminar of bone. In fact, in some specimens it is found that the fossae communicate through a small foramen. The capitellum or lateral side of the articular surface of the humerus is received into the cup shaped depression on the head of the radius and its articular surface is limited to the front and lower part of the bone. On the medial side of this eminence is a shallow groove in which is received the medial margin of the head of the radius, and above the front part of the capitellum is a slight depression of the radial fossa which receives the anterior border of the head of the radius when the forearm is flexed.

The lateral epicondyle is a small tuberculated eminence, curved a little forward and given attachment to the radial collateral ligament of the elbow joint and to a common tendonus origin for the supinator and extensor muscles of the forearm. The medial epicondyle, a little larger and more prominent than the lateral, is directed slightly backward and given attachment to the ulnar collateral ligament of the elbow joint, to the pronator teres muscle and to a common tendon of origin of the flexor muscles of the forearm. The ulnar nerve runs in a groove back of this epicondyle.

The distal portion of the elbow point is formed by the proximal end of the ulna and radius. The proximal end of the ulna presents two processes, the olecranon and coronoid process, and two articular surfaces or concavities, the semilunar and radial notches. The olecranon process was more prominent in the quadrupedal animals and was important for increasing the efficiency of the muscles in propelling the animal forward, similar to the os calcis for the leg. The tip of the olecranon is received into the olecranon fossa of the humerus when the elbow is fully extended. Its superior surface is of a quadrilateral form, marked behind by a rough impression for insertion of the triceps brachii muscle. Its anterior surface is smooth, concave, and forms the upper part of the semilunar notch. Its lateral surfaces are for ligamentous and capsular attachments. The coronoid process is a triangular eminence projecting forward

from the upper and front part of the ulna, and upon flexion of the forearm its tip is received in the coronoid of the humerus. Its upper surface is smooth, concave, and forms the lower part of the semilunar notch. The anterior inferior surface is concave and marked by a rough area for insertion of the brachialis muscle. Its lateral surface presents a narrow oblong depression, the radial notch, forming an articulation with the head of the radius. Its medial surface is rough and serves as an attachment for ligaments and muscles of the elbow joint.

The proximal end of the radius consists of a head, neck and tuberosity. The head is a cylindrical form and upon its proximal surface is a shallow cup for articulation with the capitellum of the humerus. The circumference of the head is smooth; it is broad on the medial side where it articulates with the radial notch of the ulna. It narrows distally into the neck which is surrounded by the annular or orbicular ligament. Beneath the neck and on the medial side is the radial tuberosity which is utilized for the insertion of the biceps brachii tendon.

The entire articular surfaces are incorporated in the elbow joint, surrounded by the capsule and ligaments. The capsule of the elbow is thickened medially and laterally into the ulnar collateral and radial collateral ligaments. The superficial fibers of this capsule pass obliquely from the medial epicondyle of the humerus to the annular ligament. The middle fibers, vertical in direction, pass from the upper part of the coronoid depression and become partly blended with the preceding ligament. They insert primarily into the coronoid process. The deep or transverse fibers intersect the others at right angles.

The posterior part of the capsule is thin and membranous and consists of transverse oblique fibers. The ulnar collateral ligament is divided into an anterior and posterior portion, consisting of think triangular bands. Between these two bands, a few intermediate fibers descend from the medial epicondyle to blend with the transverse bands which bridge across the notch between the olecranon and the coronoid process. The ligament is in relation with the triceps brachii, the flexor carpi ulnaris and the ulnar nerve. It gives origin to part of the flexor digitorium sublimus muscle. The radial collateral ligament is less distinct than the ulnar, passes from lateral epicondyle of the humerus down to the insertion of the annular ligament and the lateral margin of the ulna. It is immediately blended with the origin of the supinator muscle. The capsule of this joint, like others of the body, is lined with a synovial membrane and this synovial membrance is very extensive. In fact, it extends from the margin of the articular surface of the humerus and lines the coronoid, radial and olecranon fossae on that bone. It is reflected over the deep surface of the capsule and forms a pouch between the radial notch, the deep surface of the annular ligament and the circumference of the head of the radius. The total normal capacity of this joint is only 3 to 5 cc of fluid.

MOVEMENT: The elbow joint comprises three different portions: the joint between the ulna and the humerus, the radius and the humerus and the radius and the ulna. It is a ginglymus or hinged joint; the combination of movements of flexion and extension of the forearm, with those of the pronation and supination of the hand, can be performed simultaneously or independently. Pronation and supination occur primarily as the head of the radius turns in the orbicular ligament, the fovea of the head articulating with the capitellum, the medial side of the head with the radial notch of the ulna. Thus, we note that this is a very intricate, tightly fitted compact joint. The lower end of the humerus is a weak anatomic structure and it is set at a forward inclination of about 35 degrees with the shaft. This predisposes to easy posterior displacement in the cases of fracture and dislocation. In traumatic injuries of the elbow joint which may be from direct contusion or transmitted from the hand, there is invariably tearing of the capsular and ligamentous structures. This, in turn, produces an inflammatory reaction with cellular infiltration, edema and often dangerous swelling. The trauma and subsequent reaction may be severe enough to cause arterial ischemia and even lead to Voltmann's contracture.

INITIAL TREATMENT: The restoration of function in any joint is best obtained by maintaining function; thus, the treatment or/and rehabilitation begins as soon as insult or injury has occurred. Therefore, first aid treatment should be aimed primarily at preventing or minimizing additional damage to the affected elbow while the patient is being transported and until he receives adequate definitive treatment. Refrain from excessive manipulation or movement of the elbow joint following injury. Splint it in its position of injury and transport the patient rapidly but gently to a hospital or medical facility where adequate x-ray, treatment and examination can be instituted. If there is a surgeon available, an examination can be made on the spot and if there is no evidence of fracture or compounding, often a simple dislocation can be reduced immediately. The shock of local trauma often renders the part anesthetic for ten to twenty minutes or until swelling and muscle spasm begins. This is quite applicable to athletic injuries if there is a doctor available on the field at the time of the accident. However, it must always be borne in mind that any excessive trauma or manipulation may do irreparable damage. At this stage of detailed treatment, care is in the hands of the surgeon.

DEFINITIVE PHYSICAL THERAPY: The physical treatment of the elbow is comparable only to that

of the interphalangeal joints and metacarpo-phalangeal joints of the hand. As we have pointed out, the joint space is exceedingly limited, and anatomical surfaces are irregular, oblique, angulated, and mechanically intricate. The capsular and fibrous structures about the joint are tight and closely woven. Any type of injury or insult, be it traumatic, chemical or bacterial, invariably produces hemorrhage, edema, cellular infiltration, and general tissue reaction of considerable severity. These facts must be kept in mind in applying physical therapy and the modalities of rehabilitation. In attempting to restore function of any joint, the prime and most important factor to be considered is restoration of the musculature controlling the joint, provided there is no mechanical interference with the function of said joint. Therefore, in the elbow it behooves us to attempt first the restoration of function of the musculature of the arm, forearm and hand; barring mechanical interference of the joint or interarticular lesions one can expect improvement in the permanent active function of the joint to be regained in direct proportion to the strength of the musculature that controls the joint. It is important during the period of immobilization and treatment of injuries about the forearm and elbow to inasfar as possible maintain a good tissue torgor and function of the hand. One of the most important points in restoring function of the lebow is to build up a good grip in the hand. It must be remembered that this is all active force and never passive. Weight resisting exercises may be used with advantage, provided they are not allowed by fatigue or application to revert to a passive resistance or stretch of the structure of the elbow joint. NEVER USE PASSIVE FORCE IN AN ATTEMPT TO RESTORE MOTION IN THE ELBOW JOINT. Whenever force is used on the elbow, for example in cases complicated by severe fracture or in which reduction has been delayed for a considerable period of time, prognosis can immediately be labeled as poor.

The development of myositis ossificans from injuries about the elbow joint is always a potential danger. This is particularly true in children. In children having injuries, particularly dislocation of the elbow joint, the periosteum is often severely damaged. This, of course, is associated with hemorrhage and obvious displacement of some of the osteoblastic cells from the bone that, in the child, has an innate accelerated osteoblastic potential. Inevitably, if force or manipulation is used in these children to restore motion, you can anticipate the development of ossification in the fibers of the brachialis anticus or adjacent tissues about the elbow joint. Once the calcification or ossification has occurred, the treatment of choice is immobility; therefore it is essential to stop the treatment which produces the traumatic subperiosteal hemorrhage and ossification, for the manipulation or pump-handling of the joint has done its damage and will most assuredly take its toll in the form of permanent disability. The younger the patient and the more complete the immobilization, the better the prognosis. For older patients with extensive myositis and trauma about the elbow joint, the percentage of recovery is certainly limited. The antiquated custom of carrying weights, sandbags, etc., should be outlawed from the armentarium of all therapists.

MASSAGE: Massage is of benefit only where it can produce relaxation and hyperemia of muscle tissue. This cannot be done by pounding on a heavy fibrous structure, as the capsule or ligament of an elbow joint. You produce no muscle relaxation, no increased circulation, but only cellular infiltration, edema and further fibrosis or ossification. Therefore, the massage in the arm should be limited to the muscle bellies in the upper arm or forearm. The application of heat locally in moderate amounts is not contraindicated, but it is best applied with hydrotherapy. This will increase the circulation, relieve a certain amount of muscle spasm in the arm and forearm, reduce the functional weight of the forearm, and allow better and more complete active motion of the hand, forearm and elbow.

FUNCTION: While concentrating on rehabilitation of the elbow joint, it is essential that one not lose sight of the fact that the arm serves the individual not as any one component or part but as an overall functioning appendage; therefore from the individual's standpoint it is essential that no part of this appendage be neglected during the period of rehabilitation. Therefore, the doctor and therapist must concentrate on maintaining and restoring the function of the hand, wrist, forearm, elbow, upper arm, shoulder, and pectoral girdle. A definite plan and routine of physical therapy is indicated for all of these components. It must be outlined in detail to the patient and the relative merits of heat, massage, active and passive exercises explained to the patient in detail.

SUMMARY AND CONCLUSION:

1. To properly rehabilitate the elbow, it is necessary that treatment and rehabilitation begin as soon as injury or insult occurs, remembering that it is better to maintain function than ever to attempt to restore it.
2. A thorough knowledge of the anatomy of the elbow joint will be a great aid in understanding therapy for injuries to the joint.
3. NEVER USE PASSIVE FORCE IN ATTEMPTING TO RESTORE MOTION IN THE ELBOW.
4. The most important modality in restoring func-

tion of the elbow is to restore strength of the musculature which controls the joint, with particular attention to building up the grip in the hand.

5. Remember that the patient's response is to the entire appendage, and this is the basis for evaluating the result.

THE USE OF CORRECTIVE THERAPY IN A PSYCHIATRIC TREATMENT PROGRAM

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This is a report of a recently activated program of Corrective Therapy on the Acute, Active Intensive Treatment Services of the Veterans Administration Hospital, Perry Point, Md. It is not intended to leave the impression that Corrective Therapy is the most important phase of treatment for this type of patient, but rather to point out the theraputic benefits which can be derived from this type of therapy, when the Ward Physician selects his patients as he would for any other type of treatment. It also attempts to illustrate how the Corrective Therapy Section fits into the treatment team of the Psychiatric Service.

The Corrective Therapy Section of the Physical Medicine Rehabilitation Service, was activated at this hospital in November, 1950. The actual treatment program began full operation on this Service in the early part of January, 1951.

The forty-nine (49) patients assigned to Corrective Therapy, at the time of this report, were chronic, and acutely disturbed psychotics, mainly schizophrenics. The greater percentage had already been treated by the various Shock Therapy methods (Electric and Insulin), and several had Bilateral pre-frontal lobotomy operations performed.

The patients prescribed for this treatment, as a whole, presented the following problems: (1) Inability to participate in the other hospital activities, due to their uncontrolled, disturbed, behavior patterns; (2) Those assigned—which was a very low percentage —to activities, took an apathetic attitude toward them. As a result, their participation was performed in a very passive manner. The one trait that was most common was combativeness, followed by destruction and unpredictable behavior. As a result of these three traits it was necessary to use sedative Hydro-Therapy treatments rather frequently. These treatments consisted mainly of, wet sheet packs and continuous tubs. A great majority of these patients were also negativistic and asocial.

The treatment aims of this program fell generally into two classifications: (1) Socially acceptable methods of expression of aggression; (2) Increase in Social participation. The methods used to accomplish these aims were as follows: After a review of each individuals case an attempt was made to determine the operating level of the patients, and to prescribe for this level of activity. The activity was then constructed to meet his needs and capabilities. The size of the groups was controlled by this factor. Several of the group prescribed were so combative and unpredictable in their behavior that it was necessary to have them begin their participation in this activity on an individual basis. These patients were treated individually for periods of forty-five (45) minutes each, five (5) days weekly. An attitude of unsolicited friendship was used, and their participation was closely supervised. The first activity consisted of an opportunity to express their aggressiveness in a socially acceptable manner. This was accomplished by using the heavy striking bag. They would then be encouraged to attempt the use of the light striking bag. At no time was the patient corrected on his technique, in the use of these two activities, but encouraged to strike the bags as hard as possible. The reason for this was not to place too many restrictions on the individual, but allow him to express his aggressions and hostility, in order to prepare him for some other activity which was more demanding. Neither of the two individuals, who were treated individually, had any marked degree of coordination, but performed in a very aggressive manner, striking the bags as hard as possible. As the patient began to quiet down, he was then moved to another type of activity, which would place moderate demands on his personality. Foul shooting of a basketball was used for this activity. The activity began with the use of one basketball, and as soon as the patient showed some degree of proficiency a second ball was added. The patients began this activity standing very near the basket, in order to allow them to score easily, with the thought in mind that this would give them added incentive. It was felt this activity would maintain the patient's interest, yet not be too demanding of his ability. Liberal recognition was given when baskets were made, and continual encouragement was given when baskets were missed. At no time was the patient censored for his method of shooting, nor were any attempts made to correct his faults. The use of do's and don't's were kept to a minimum. The goal was not to make an athlete of outstanding ability, but allow the patients an opportunity to gain narcissistic gratification. The patients treated indi-

vidually in this program, after a four (4) week period, became actively interested enough, in this activity, to participate in a group. However, when first entering the group, their participation was limited to individual activities. They were now participating in social activities.

The remainder of the patients had been activated in small groups, comprising six (6) or eight (8) patients each. They too, were assigned big muscle activities, in an effort to allow them to express their aggressiveness in an acceptable manner. As they began to show signs of diminishing interest, they were rotated to another activity; i.e., from heavy striking bags to light striking bag, to jumping rope, to shuffle board to basketball, etc. Each time a patient's activities were changed his reactions were closely observed. Those who showed signs of becoming disturbed, were then encouraged to attempt some soothing activity which would place moderate demands on the personality, yet not push him over his frustration tolerance. Activities used for this type of patient were catching and throwing old battered, sixteen (16) inch softball. This type of equipment was used to prevent injury to patients and personnel in the event one of the individuals threw the ball too hard, or deliberately struck another patient with it. A basketball was also used in this type of therapy. As the patients began to display more acceptable behavior patterns, basic socialization activities were suggested and encouraged. Where previously personnel would play catch or shuffleboard with them, they were now encouraged to play among themselves. This was the beginning of the resocialization process, for in this type of activity they began conforming to a standard. Several patients who had shown marked interest in basketball were encouraged to shoot baskets, as a group. They then began to move freely around the area of the basket, passing and shooting the ball among themselves. A feeling of friendship began to develop in this activity, which was carried on to the ward, and in their associations with the other patients and personnel. For those patients who were very aggressive, and who needed socialization activities, but were yet unable to participate in an activity as demanding as the complex movements required in the basketball type of activity, a group was formed to pass a medicine ball. This activity served several purposes when organized properly. It was basically used for resocialization, but also used for a socially acceptable method of expression of aggression, in that those patients who were overly aggressive were placed in a position where they were required to throw the ball a greater distance, thus causing them to use more energy. Those patients who were apathetic, and needed encouragement of expression of aggression, were placed in positions where the distance they needed to throw the ball was less than the aggressive patients distance. As the group began to socialize more freely, the stimuli given by the Therapist was diminished. As the patient's interest in this activity would show signs of diminishing he would be placed in another activity, either of a social nature or one of individual participation. When interest was aroused, and the group as a whole indicated the need for more activity, another ball would be added. The addition of this extra ball doubled the demands placed on the individual personality. It kept the patient in constant touch with reality, for now it was necessary to constantly be on the alert for a pass from a fellow patient. Another method which was used to encourage the expression of aggression, and form a basis for the resocialization process, was to have two members of the group use the heavy striking bag simultaneously. This activity again was not used for the entire group but for specially selected patients. It was found that one patient, in particular, who was very assaultive, aggressive and unpredictable, would only "play," with this activity. When attempts were made to stimulate him into a more active participation, he would become hostile, aggressive and threatening. It was then suggested that he hit the bag from one side while the therapist hit it from the opposite side. When another patient, of the aggressive type, showed interest, he was encouraged to take the position of the Corrective Therapist. The response was immediately gratifying to both individuals' ego, for they began verbalizing in a friendly manner and attempted to out do each other. It is still necessary at times, to use this activity to manage this one patient.

The length of time consumed in the treatment periods is flexible and is guided by the individual patient's behavior. The program is arranged to use periods of ninety (90) minutes duration. Some patients require less than this amount, and their participation is so guided. Others need more, and are then treated for two or more periods. Several who are in the acute stages of Manic Depressive reactions, Manic type, require as many as four (4) periods. This same procedure also applies to those other individuals who are excited or elated. Participation is guided by the day by day reactions of the individual patient to his mileu. As the interest of the patients increased, the groups were reassigned and some were made larger. One group which began with six (6) members, now average fourteen (14) patients daily. This allows more patients to be assigned, and also to give more individual attention to the more asocial and apathetic individuals. All patients received tonic Hydro-Therapy at the end of their Corrective Therapy Session.

In the absence of a control group, it is not possible

to say with assurance that all the improvement reported is due to the Corrective Therapy technique. However, it is the impression of the professional staff that the reported improvement is largely, if not altogether, the result of the Corrective Therapy Treatment Program. The ward as a whole is much quieter, the number of altercations has been greatly diminished. Several of the patients who were assigned to other activities, but took an apathetic attitude toward them, are now showing more interest. Three patients of this group have been transferred to different Services, and have been placed on privilege status. One of these has been placed on Trial Visit. One has been discharged. Two patients have been transferred to other wards which carry on a full activity schedule. Fifteen (15) of these patients have been able to increase their activities to participation in the general recreational activities, and several of the fifteen (15) mentioned have been taking part in Occupational Therapy, which they were previously unable to do. Three of the patients had required the use of seclusion, due to their behavior and inability to make a ward adjustment. They are now assigned to a ward, but continue regular attendance in the Corrective Therapy treatment program. One of the three patients is now on a full activity schedule, attending all recreational activities. Another of the above mentioned seclusion patients required thrity-two (32) wet sheet packs for the months of November and December of 1950, as sedation. For the months of January and February of 1951 this patient required seven (7) wet sheet packs, as a sedative measure, and was removed from seclusion status. For the months of November and December of 1950, immediately preceeding the activations of the Corrective Therapy treatment program, it was necessary to administer five-hundred (500) sedative Hydro-Therpy treatments to this group of patients. Immediately following the activations of this program, during the months of January and February, 1951, it was necessary to give only one-hundred ninety-three (193) sedative Hydro-Therapy treatments to this group of patients. Seventy-six (76) or 39.4% of these treatments were administered on non-operating days, such as Saturdays, Sundays and holidays. The overall average was reduced from 8.20 daily to 3.33 daily. The average for operating days was 2.87, while for non-operating days the average was 4.47. There was an over-all reduction of 61.4% in the use of this type of sedation. Several of the patients who previously required sedative Hydro-Therapy treatment of the wet sheet type, were now able to receive the required sedation by using the continuous tub, without the use of a restraining cover.

It is felt that the use of this type of treatment program fills a definite need for the psychiatric patient, for through its use, this type of individual is allowed to express himself, when there is no other outlet. It affords an acceptable outlet for aggressions. It is a stimulating modality for the regressed type of patient. One might theoretically postulate that patients in whom verbal channels of communications have broken down, could do better approached on a level of a physical or psychomotor activity, accompanied by the friendly, non-threatening, accepting attitude of the therapist. The latter aspect, we might assume, is the most important effective theraputic tool in the entire program. Without the sensitive, empathetic therapist, who is sincerely interested in the patients, the program is doomed to failure. In other words, the activity is secondary, and the emotional rapport is of primary importance. It follows the stablished pattern of psychotherapy in that no demands are immediately placed on the patients when first prescribed, and when demands are made, they are progressively increased or decreased, depending on the patient's immediate needs and tolerance. An additional value of this activity is the opportunity it affords the professional staff to gain new insight into the patient's personality structure and diagnosis, by observing his behaviorial reaction patterns in these group situations. Corrective Therapy does not replace any of the other members of the treatment team, but is an important adjunct to effective psychiatric treatment. The results achieved up to the present time are a result of close team work, comprising all of the allied professional personnel, under the direction of the Ward Physician.

In compiling this report I wish to express my appreciation for the cooperation received from the Manager, the Chief of Professional Services, the Ward Physician and the Executive Assistant of Physical Medicine Rehabilitation.

OPPORTUNITIES FOR REHABILITATION SPECIALISTS

HARVEY E. BILLIG JR., M.D. F.I.C.S.
Medical Director, The Billig Clinic for Rehabilitation
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Initiated by the now famous April 1944 "Report of the Baruch Committee on Physical Medicine" pointing out the deplorable lag in research on and development of therapeutic physical medical methods, nearly a decade of intense development has taken place.

Already there are active departments and professors of Physical Medicine in many of the Medical Schools. Veterans Administration Hospitals consider rehabilitation, with its con-commitant emphasis on physical function restoration, of prime importance. Rehabilitation centers and clinics are springing up throughout the country and chiefly stressing the Physical Medical aspect. Many of the established general "clinics" have already incorporated a department of Physical Medicine with a full complement of doctors and therapists. The literature is full of research reports and therapeutic methods dealing with the heretofore neglected subect "physical function."

Historically speaking and still hanging on to hamper progress, has been the overemphasis on "Rest in Pain" emanating from a famous article written years ago which was picked up and expanded in thought to include all conditions. As a result of hampering by the weight of that thought many an arthritis specialist has nearly "blown his top" in attempts to institute exercise schedules to prevent development of or instigate recovery from contractures, muscle atrophy, and bone atrophy. Workers in the field of Poliomyelitis confronted with the same resistance have been stimulated to intensified effort in order to demonstrate the effectiveness of mobilization therapies. One famous nurse has campaigned the world to promote the beneficial effects of mobilization as compared with immobilization. Many historical and electromyographical studies have shown the harmful effects of immobilization to even normal muscles.

Considering all this rapidly expanding understanding of the factors controlling physical function, the need for therapists has become acute. Private clinics, doctors' offices, rehabilitation clinics, mental hospitals, veteran administration hospitals, medical schools, corrective physical education and physical education departments of the schools, etc., all are going to require, in increasing numbers, therapists who not only are adequately trained but have academic credential standing. This latter is necessary so that any individual therapist who shows aptitude and so desires will be qualified academically to continue on to obtain higher degrees (M.A., Ph.D., D.Sc., etc.) and hence fit him for teaching, departmental head or professional rank.

There are a number of lines of approach to physical function that, as they become understood, will require not only doctors but therapists as well. Several examples are:

1. Growth and development: During the maturation phase of development the nervous system increasingly expands the number of neurons able to discharge an impulse (action potential, depolarization, etc.). As this expansion occurs, function increases (a.g., muscle function coordinate patterns) in a characteristic sequence of patterns of increasing complexity, a part of the set sequence of embryological maturation characteristic to each species. In giving therapeutic exercises particularly to children, it is necessary to ascertain the stage of sequential patterning that the child has reached so that the exercises will not be rendered incomprehensible by being presented in terms of developmental patterns that the child has not as yet reached. A great deal of attention and further exploratory research needs to be done on this subject.
2. Conditioned patterns of neuro-muscular function: We are all aware of the trials and tribulations of trying, for the first time, to drive a clutchless car, pumping our left leg, now uselessly, in accordance with the old clutch use conditioned pattern. There are thousands of such conditioned patterns in every person and they vary with each patient. An accurate appraisal must be made of these patterns so that therapeutic exercises may be given in accordance with them. Conditioned patterns of muscle control are a result of plastic changes in the neurons of the cerebral cortex and are very difficult to change so that frequently it is necessary to superimpose new conditioned patterns and "warp them in" by frequent prolonged repitition. It is notorious that the old patterns will tend to reappear in times of stress and trap us (the faulty "hitch" in baseball batting).

   Reeducation for neuromuscular control of a flexor tendon transplanted to perform the function of an extensor is a problem in conditioned reflex training and again, in times of stress, even after many years, the control may tend to revert to the old patterns. Many times the necessity of this training is not recognized so that the benefit of a transplanted tendon is lost.
3. Sherrington's reciprocal innervation reflex coordination: The use of the balance of muscle power in terms of flexion versus extension involves the rapidity with which one set of muscles can be relaxed to allow the opposing ones to perform the motion with their contraction. If this capacity is low, we tend to "tie up" (440 yard dash) or develop Parkinson-like tremors, or to "pull" a muscle if we try to make the reciprocal motion go faster than the "Sherrington's" will work. Enhancement involves extensive, very slow, passive conditioning training. Again the field is wide open for investigation.

It is hoped that the above dissertation will serve to illustrate the fact that there is both a present and future need for soundly trained personnel in the field of physical function therapy.

The Forum

Editors Note: Three new questions were published in the last issue of the journal . Two opinions on but one of the questions are published in this issue. Since the success of the Forum will be dependent upon reader response, your editors urge that you contribute both questions and answers. Your response is indicative of lack of interest. We will welcome your constructive criticisms.

What constitutes a good progress note?

From: LEON EDMAN, Field Supervisor, Area Medical Rehabilitation, VA Regional Office, Minneapolis, Minn.

This area is considerably interested in the writing of progress notes. We are currently giving it special emphasis in our visits. An answer to this question is—that first of all it depends upon what the prescribing physician expects, since it is for his information that the note is being written. However, general statements can be made as to what they should contain.

Statements should be accurate and measurable terminology should be used. Ambiguity, resulting from such general statements as, "patient improved" should be avoided. For Corrective Therapy, we feel that functional terminology should be used. When speaking of ambulation, for example, the distance traveled; the type gait used and the time consumed should all be recorded exactly and precisely. The appearance of the patient who shows fatigue, abnormal pulse and respiratory responses should be recorded. Evidence of tenseness and inability to relax should be noted. An estimate the patient's ability to perform the activities of daily living at various stages of his progress, will be helpful. The attitude and cooperation of the patient needs to be reported.

For the psychiatric patients the progress note is not as easily written in exact and measurable terms. For this reason, it is very important that the terms used are consistent, and that an adective like "cooperative" does not mean for patient "A" that he participates whole heartedly, when the use of the same term for patient "B" simply means that he is not negative. Of prime importance are the attitudes and behavior observed in the patient. We feel it is also important to describe the specific activity the patient participates in or avoids, as providing a clue to his personality. This point is frequently omitted in progress notes.

Progress notes are by the nature of their need, to be brief, concise and limited as to the amount of information they can contain. They can be amplified by the use of charts and forms of the testing and record type as well as written information for our own personal use. The progress note itself can made reference to this additional information. But here again, we must be careful to avoid ambiguity. We must know that when we refer to a specific technique, we mean exactly that. For example; the DeLorme technique has been modified so many times and there is such variation in its use, that to merely state that you are using the DeLorme technique may be misleading. An initial evaluation of the patient most certainly should be written as the base point from which to measure progress.

From: ARTHUR S. ABRAMSON, M.D., Chief, Physical Medicine Rehabilitation, VA Hospital, Bronx, New York

Progress notes are for the use of the physician in order that he may be able to determine the effectiveness of the therapy he has prescribed. He will receive simultaneously, the progress notes from all the therapeutic disciplines involved in the prescribed program. It is obviously difficult for the busy physician, who must integrate programs of many patients, to wade through a large amount of writing, some inconsequential and some containing useful information. For this reason, notes must be *succinct, simple and significant.* They should not give information contained in forms designed to record quantitative data obtained from testing.

Progress notes should give an idea of the patient's attitude and enthusiasm, his concientiousness and the contribution he makes. The effectiveness of my dynamic therapeutic program depends on the physical reserve and the personality of the patient. The physical reserve is determined to some extent by the initial examination and testing and more fully by the patient's response to a test therapeutic regime. The patient's personality can be superficially evaluated at the initial examination but more profoundly by observing his response to his program.

The physical response should be recorded in the notes by a simple statement such as: "The patient is making moderate improvement in function." The physician will determine the degree of improvement by re-examination and study of the data obtained from repeated testing such as would be contained in Activities of Daily Living forms.

The more qualitative the nature of the patient's response, should form the bulk of the note and should contain statements such as "the patient attends his program poorly"—"he does not try hard enough; is unenthusiastic and does not understand the rationale of what is being done for him." Sudden changes for the worst in the patient's physical or mental status should be recorded but must be preceded by oral notification of the physician.

To summarize, progress notes should succintly contain all significant facts, usually qualitative rather than quantitative.

"From Other Journals"

RICHARD BROWN, Assistant Director Water Safety, American National Red Cross, "The Breath of Life" *Journal of the Association for Health, Physical Education and Recreation, February,* 1952.

Following extensive research on various types of resuscitation, The American Red Cross recently adopted the use of the Holger-Nielson method to replace the Schaeffer method which had been in use for many years in their First Aid, Water Safety, and Accident Prevention programs.

The new method is performed with the subject in the prone position with the head turned to one side and resting on the hands with the elbows outstretched. The operator kneels in a position directly in front of the subject and applies a sequence of back pressure and arm lift alternately. The recommended cadence is twelve cycles to the minute.

The basic differences in the two methods lie in that the new method introduces a step which actively forces air into the lungs. This is accomplished by the arm lift and can be termed a variation of the stretch reflex to initiate inspiration. The pectoralis major and minor, the scaleni, and the intercostals would be primarily affected. The old method relied on the elastic recoil of the chest and internal organs to induce air into the lungs. Expiration is also facilitated indirectly as a consequence.

The new method is much less strenuous to the operator, and the change of operators, if required, is greatly facilitated by the fact that it is no longer necessary to take a position astride the victim. SHW

RUDOLPH EKSTEIN, Ph.D.* "On the Nature of the Psychotherapeutic Process."** *Department of Medicine and Surgery, Information Bulletin, Psychiatry and Neurology Division, Veterans Administration, Washington* 25, *D. C.* Oct. 1951.

In an address presented in Budapest in 1918 at the Fifth International Psychoanalytical Congress, Dr. Sigmund Freud indicated the great problem of bringing help to the large mass of sufferers with emotional disorders. He inferred that analysts were not content to remain in the ivory tower of a procedure which, because of its cost, its relevance to certain neurotic syndromes only, and because of the small numbers of trained analysts, its applicable even today only to a small group of people.

During the 31 years after Freud's altruistic and inspiring message in 1918, we have made many strides. If the address were to be repeated today it would be heard as a condescending statement about a well-developed body of generic psychotherapeutic knowledge. General psychotherapy need not be considered a diluted psychoanalysis, but rather as having a process of its own. The scientific evaluation of different psychotherapeutic schools, of their claims and counterclaims, has barely been started and remains an open field for research. (9).

It may be useful as a first step in this direction to lift out of the psychotherapeutic process a number of elements which are contained in it, and which are common to psychotherapy regardless of the school of thought which inspires it.

These elements are the problem of *beginning* in psychotherapy, the problem of the psychotherapeutic *relationship* (or transference), the meaning and the changing use of *structure* in psychotherapy and the use of *time* in psychotherapy. I will also refer to the use of the *metaphor* in psychotherapy, the role of the *"secret"* in psychotherapy, the problem of the *past* and *present,* and finally the problem of *ending* of the helping experience. (While a theoretical bias of my personal psychoanalytic experience will shine through the material, the reader may translate these thoughts into his own language, and thus make it amenable for discussion.)

Certain problems arise when two people get together for the first time, regardless of whether the purpose is romance or a business relationship, or whether it is a teacher-student relationship, or whether it is in some other situation. Most people involving themselves in any such relationship will try to use the first stages to evaluate the other person to see if the other person could possibly fulfill their need, the explicit or implicit purpose of the partner, and, at the same time, they will attempt to give the other a certain picture of themselves. The beginning in many ways, then, is a testing-out process and each partner tries to test the other and, at the same time, tries to pass the test. Such mutual testing is limited and regulated through the "power relationship" that exists between the two, through the customs of our time, and perhaps even more so through the psychologic characteristics of the personalities involved. Not all such testing is of a conscious nature. While this mutual testing never stops, it is in the foreground at the start of a relationship and thus dominates the psychology of the beginning.

Such testing goes on not only in a constructive relationship where both partners seem to have a common purpose, but goes on as well in those situations where people get together in order to fight each other, perhaps in order to destroy each other. Think only of two deadly enemies, of opposing armies in the field, of the relationship between prosecutor and criminal, gangster and policeman, security agent and foreign spy, for instance. In these destructive relationships the testing will be of a somewhat different nature. One partner will try to disguise his strength, his intentions, his plans, his psychologic makeup perhaps, while the other will try to break through the disguise, will try to discover the secret and, at the same time, will protect his own identity and his own interests. These testing relationships will be dominated much more by strategy of the "poker face" than by the intention to show oneself at one's best, with a most pleasant face and flower in buttonhole as during one's courtship days.

While in the first set of relationships it seemed that the purpose between the partners involved was a common one, it is quite clear that in the second set of relationships the partners do not agree on the purpose and, if they do—aware as they may be, for example, that they are enemies and that one must defeat the other—their purpose is indeed one of complete indifference; they get together in order to be opponents.

Life situations, unfortunately, are even more complicated. During the testing-out procedure that goes on among people, purposes and needs may change, and potential partners may become opponents; a relationship of mutuality may turn into one of exploitation. Think, for example, of the romantically inclined young man who meets a young woman, and while courting her, tests her, so to speak, with the secret phantasy that some day she may be his wife. Another aspect of his personality, however, tests her with the powerful purpose in mind that she may meet the need of a casual love affair which, however, because of his moral standards would make her unavailable to him as potential marriage partner. In addition, since he also may be a young conscientious scientist, part of him may think of her as a potential partner in objective, scientific endeavors and his testing of her turns out to be also a testing of himself, a constant battle between his own conflicting needs and desires. Similar processes may go on the young lady as well. We can not predict what the two young people concerned want to test in each other, what they may find out under specified circumstances, and what the nature of the relationship will ultimately turn out to be, particularly so when it is remembered that the partners test and evaluate each other not only on a conscious, but on an unconscious level as well.

Psychotherapy as a professional skill encounters many of the possibilities described above as the "beginning" phase (2) and is dominated by the patient's desire to find out if the therapist can help him while the therapist wants to find out if her can be of assistance. The patient brings his needs, the complaints about his symptoms, and his desire for help to the therapist. It is the task of the therapist to see if and how he can meet these needs in a constructive sense. The basic difference between the psychotherapeutic relationship and all these others, depends on these few facts. In any other, relationship both partners bring their own needs into the situation. This takes place during the courtship of the young man and the young woman, or between the employer and the employee. Both partners bring personal needs into the situation and, while each may be ready to take into consideration the needs of the other person, each wants to have his own needs met as well. Professional psychotherapy is different inasmuch as the

*Menninger Foundation, Topeka, Kansas.
**Abstracted from a lecture given at the Seminar for Hospital Psychiatrists, VA Hospital, Topeka, Kansas, April 2-6, 1951.

psychoterapist has learned to free himself from his own needs, healthy or neurotic as they may be, and uses professional relationships only in order to determine if he can meet the needs of the patient.

This is perhaps the most important difference between the professional relationship and the social and other relationships. Because of this difference, it is possible that therapists are able to help their patients, while they cannot therapeutically help their own friends and family. Here their own needs, their own emotional entanglements would interfere with the professional task.

During his training it is important to help the future psychotherapist to understand and to master his own needs as they may interfere with the psychotherapeutic task. Personal analysis, or at least professional supervision, (3) are important tools which assist in the development of the professional self and help free one self to a large extent from the domination of personal needs which may interfere with one's therapeutic functioning. The well known rule of psychonalysis about avoiding social contacts with one's patients stems from this.

The psychotherapeutic relationship as a professional relationship differs from social intercourse in that it has certain structures, certain conventions, and a philosophic or theoretical framework. It is an essential part of the psychotherapist's function to maintain these clearly in spite of all the usual efforts of the patient to convert the psychotherapeutic relationship into a social relationship. This could nullify the therapist by making it a repetition of previous neuroti crelationships which have been, in part at least, the very cause of the illness.

The patient will come into his first interviews with a real desire for help, but his idea of help will be patterned by all his previous efforts to obtain help from other people, will be a repetition of them, and he will thus express conditions for help which the psychotherapist cannot meet unless he is prepared to repeat the patient's vicious circle of the past.

The therapist's job during this initial period of testing is to understand what are the patient's neurotic conditions of asking for help and to make clear to the patient his own conditions and methods of tendering help. A problem that patient and therapist face together is to find out if they can work together in spite of this difference, if they are prepared "to take a chance" with each other. To illustrate this point: A woman might come to the psychiatrist and present her problem as a marital one. What she wants the therapist to do is to call the husband in and to change him. All her previous life she has been trying to use other people, her parents or her friends, in order to change undesirable elements in her environment. This is her unconscious or conscious desire when she sees the psychiatrist and complains about the certain somatic symptoms, the cause of which she feels lies in the husband's undesirable traits. The psychiatrist who would completely take over and use himself as an extension of the woman's neurosis would not help her but would only contribute to the prolongation and intensification of her illness. While he may be ready to give recognition to the suffering that she goes through, he will have to bring about a state of affairs during this initial interview so that the woman is able to take some responsibility for her illness and to take back into herself some of the projective elements.

Often patients come to us at a point of emergency. They may demand to be seen immediately. They may insist that the therapist take over their problem completely. In very serious mental illness such total responsibility, such total taking over a parental and custodial function, may be temporarily necessary. At the same time, however, psychotherapy—if this method is indicated—must come to the point, and the sooner the better, where some of the responsibility is the patient's and where he meets the difference of the psychiatrist.

During the process of evaluation of the needs of the patient, the study of his ways of controlling the world and others, the study of his conditions for help, the therapist is at the same time making a diagnostic evaluation. Diagnosis is a part of the psychotherapeutic process and does not just take place before the psychotherapy starts. Psychotherapeutic skill may be developed which makes of this mutual testing evaluation between patient and therapist the first dynamic steps which will lead to the core of the problem which the patient brings and which he tries to solve together with the therapist.

This set of examples from social relationships illustrates that the psychotherapeutic relationship is experienced by the patient in many ways, both in and out of awareness. During the psychotherapeutic process, the patient may place the therapist in the role of friend, parent, competitive sibling, brutal authority, lover, seducer, deadly enemy, or other roles which the therapist must recognize if he is to understand the emotional world of the patient whom he treats.

The developing relationship of patient and therapist during the testing-out, re-evaluation, restatement of needs, and changing of purposes, is marked by considerable emotional intensity as in the emotional world of the two lovers who do not quite know at the beginning what they will mean to each other in the end. This leads to consideration of the concept of "relationship" or transference and counter-transference, to use technical terms derived from classical psychoanalysis. Whenever a concept is carried from one specific field of application into a broader field, we may overlook the changes of meaning which thus necessarily occur. In psychoanalytic theory, transference relates to the psychologic fact that people transfer consciously and unconsciously established relationship patterns from the past, particularly the infantile past into new relationships, and specific uses of this phenomenon during treatment are implied. The phenomenon of transference can be observed in any relationship, in a casework relationship, in vocational guidance, or in the different forms of psychotherapy as known today, but we find only in analysis the specific technical use of transference interpretation. The other semantic difficulty is the frequent failure to differentiate between the surface aspects of a relationship (described by some as "rapport"), and the more subtle aspects which relate to unconscious transfers from past relationships.

The psychotherapist, who attempts to establish a "good rapport," is not establishing transference, but, in any relationship, even if positive rapport can be maintained throughout, one will find elements of transference. As a matter of fact, these aspects of transference are a necessary precondition to the application of psychotherapy. The patient who cannot establish a transference, so to speak, is not amenable to psychotherapy. For years, it was assumed that the schizophrenic patient was not capable of transference and therefore psychotherapy was not attempted. This point of view is now slowly being changed by those who attempt to treat schizophrenics psychotherapeutically.

This discussion about the psychology of the beginning in psychotherapy concerns those aspects of rapport or transference which one is most likely to observe during the beginning of treatment. As the process develops, the relationship will change and different feelings toward the therapist, postive or negative, and different in intensity and quality, will occur and must be dealt with.

Psychotherapy is a unique human relationship in that the therapist minimizes or controls his own needs in an effort to meet the needs of the patient therapeutically. An atmosphere is established in which the patient receives as little direction as possible or desirable from the therapist for his trend of thought. His expressions then represent, as much as is possible, his concept of the role with which he invests the therapist. Under these conditions the stage is set for the observation of transference development. While ideas about the therapist brought up by the patient during the interview often reflects the transference problem, it must be kept in mind as well that many expressions of approval or disapproval, of like or dislike, are not necessarily repetitions of the past, and do not refer to transference but to rapport, to the present situation, and may well be realistic evaluations of the therapist.

The therapist, too, has problems in this relationship which are usually summarized under the heading of counter-transference. In one sense, counter-transference is absolutely necessary for therapy, but it can also be an obstacle to therapy. A realistic reaction to the patient's behavior may not be a "sign of counter-transference." The term may be reserved for these feelings and reactions of the therapist which are based on his own unresolved infantile conflicts. Certain counter-transference reactions, the sudden observation of a feeling toward or against the patient, the sudden occurrence of a certain idea, can, if dealt with directly and if understood properly, actually aid therapy because it helps us to understand the patient to empathize with him. As a matter of fact, the therapist who would want to work without "feeling" reactions would at best react intellectually to the patient, and would not develop genuine psychological sensitivity.

Much ado has been made in the literature about the difference between the so-called negative and the so-called positive transference and counter-transference. Such statements seem to imply that the positive transfer or counter-transference is

good for psychotherapy, while the negative one is bad and impedes treatment. These terms, "negative" and "positive," derive from a time when the behavior of the patient toward the therapist was by implication judged as being good or bad. Actually, both negative and positive feeling reactions, and the endless chain of feeling patterns in between, may stand in the service of progress in treatment or may equally often turn out to be obstacles. Even if they become obstacles, they are an unavoidable and necessary part of the psychotherapeutic process. Calling them positive or negative is merely judgmental and indicates that the psychotherapeutic process has been accepted not in its total complexity, but only in terms of these aspects which we judge to be good or positive, friendly or likeable.

The over-compliant patient who always wants to please the therapist, who sees in the therapist a Savior, the best person whom he has ever met, and so forth, may actually unconsciously use such image of the psychotherapist as a resistance to treatment. Only as he becomes aware of the function of such behavior will he discover other aspects of his feeling toward authority which are equally true and important but were forced to remain under control behind his subservient front.

A psychotherapist may be particularly impressed by the sordid fate which the patient seems to suffer at the hand of his spouse. He may so very much over-identify with the patient that he, too, may be willing to blame the marital partner rather than to recognize the projective tendencies in the patient. Such over-identification may be a positive counter-transference but it would be an obstacle to treatment. However, there are many instances in which the so-called negative transference or counter-transference might actually be in the service of process, of moving toward health.

Most dynamic psychotherapists, even though not actually using the technique of interpreting transference, will take cognizance of transference and use it to understand the psychic situation. Some psychotherapeutic methods, as, for example, until recently the nondirective method of Rogers, will not explicitly make use of transference or observe it, but transference phenomena often can be recognized as a driving force in any other kind of psychotherapeutic relationship.

Another concept which may clarify the nature of the psychotherapeutic process is the concept of "structure." (4) Think for a moment of two players who play a game of chess and, later on, a game of tick-tack-toe. In both games their intelligence, their knowledge of the rules of the game, their experience with the game, their particular attitude to attack and to defensive play, and many other emotional aspects, will be decisive in which way the game is played and in which way it will end. Though both games are played by the same players, the nature of the game will determine to a large extent what can go on between them. The rules of the chess game and the rules of the tick-tack-toe game will limit or define the play relationship between the two players. These rules are arbitrary; they come from a book or are based on conventions understood by both.

The rules of the game which define and limit the relationship between the two players may be termed the structure of the game. This structure, while not the only determinant, will constitute a framework within which this process in all its richness may go on. In both of the game structures one can win or lose the game, one can delay, one can obsess, one can come to a quick decision, one can take risks, or one may be afraid and "run away" so to speak. The observer will see all of these moves or counter-moves as they are structured through the arbitrary rules of the game.

Schools of psychotherapy impose different structure on the treatment relationship. These structures will be responsible for part of what one can observe in the relationship, as well as for part of what will remain inaccessible to view.

The structure of a relationship may be considered in terms of the obligations imposed on us. All interactions with people take place in some context of such requirements, obligations, and demands, hence the concept of structure is applicable to all psychotherapeutic methods. Any method will be understood better if we take time to study its specific structure. Even an extreme "laissez faire" situation or a situation of near anarchy is not really "unstructured," since it imposes very real demands and obligations, although these may be very different from those in a more authoritarian situation. It is the structure of a situation which permits certain forms of behavior to emerge while suppressing other forms. In therapy, the conditions imposed by our society, by the hospital administration, and the conditions which we (because of our convictions) impose upon our patients and those which our patient (because of his illness) imposes upon us, all help determine what types of activity will occur in the therapeutic situation.

It is the task of the psychotherapist to create a useful structure for the therapeutic situation. This task is much simpler in psychoanalysis for example, where the structure of the analytical situation remains more or less constant throughout treatment. The psychotherapist who works with other means is not so well protected by a consistent and well-defined structure; he is in a much more difficult position. He must be very flexible, able constantly to modify the structure, not only as regards his approach to different patients, but also for the same patient at different times. With so many uncontrollable outside factors impinging upon the therapist, it is never possible to be a complete master of the resulting structure. Despite this realization, there remains the obligation to understand the structure which we do use regardless of whether it is of our own making.

Many examples of structure relate to the responsibilities of hospital administrators and Chiefs of Sections or clinics. Think of the practice in many psychiatric services which assigns a patient for psychotherapy to one worker, while another worker will be responsible for his pass or ground privileges or his medical needs. If the psychotherapist himself were to be responsible for pass privileges or his medical needs, and so forth, this indeed would introduce a new rule of the game and would have consequences for the psychotherapeutic process. Think of the psychotherapeutic rules about payment which apply in private practice. In a State or Federal hospital, the very different views about money and personal financial responsibility will influence the nature of the relationship between doctor and patient. Think about the problem of authority and control in the Armed Forces, problems of secondary gain, lack of motivation to get well; think of psychotherapy within any kind of authoritative setting whether it be the Army or within a prison. If the patient sees the therapist as a representative of the Armed Forces or of the legal authorities, this will influence the rules of the game and will have tremendous consequences for the treatment process. These must be well understood if the therapist wishes to use his function as a representative of authority in a constructive way, rather than permitting it to become an obstacle.

Structure may be experienced (both by the patient and by the therapist) as something imposed from the outside, as an obstacle to treatment rather than as a help. Only when he realizes that any type of psychotherapy, and psychotherapeutic relationship, works with *some* kind of structure, will he learn to *use* the rules of the game rather than to resist them as a hindrance. Hospital psychotherapists have to be taught to work through their structure, rather than to experience the structure as an obstacle that the hospital administration has put between them and the patient.

One therapist might think, for example, that, if only he had complete hospital authority and could provide any kind of privilege for his patient, he might succeed in therapy. However, he would be constantly in danger of opposing his team of co-workers and the hospital administration in behalf of "his" patient. Often the psychotherapeutic process may suffer because of the psychotherapist's inability to work with those aspects of structure which were not of his own making, but were rules created by society and by the authorities to which society delegated responsibility for the establishment of constructive and productive hospital settings.

One of the prime problems in hospital settings is to teach the young therapists those attitudes which would permit them to accept the team, the hospital setting and administrative authority; and to show them how to participate in its constant re-evaluation. In short, to learn how to work *with* rules, with limitations, and with structural aspects rather than *in spite of* them or *against* them.

One of the patient's difficulties will always be the acceptance of structure. Like the angered child who cannot constantly win and who throws the checkers off the board, the patient will be inclined to fight against the structure, to struggle against rules, and thus to impede his own recovery. How to utilize such struggle against structure and how to help the patient use it are problems of skill which impose serious demands on the therapist, his teachers, and administrative supervisors.

The concept of *time* in therapy is a specific use of an element of structure. Arbitrariness seems to enter in the decisions to use time in certain ways. All schools of psychotherapy

have some rule about the use of time or structural arrangements about time. Classical analysis requires, in general, daily sessions with the patient extended over a number of years; but even the classical analysts do not entirely agree about the use of time. The English training system, for example, requires from its candidates at least 3 years of analysis, while the American training system considers an average of 2 years as a possible minimum. The "Chicago School" of Analysis has come to believe that training can be shorter, and a number of analysts there are spacing sessions in very different ways. Some who do psychotherapy with schizophrenics give time to them without limit for a certain part of the treatment. Other therapists (such as some of the nondirective school) try to leave the problem of time entirely up to the patient, do not control it, but see the patient, insofar as it is possible, as often as he wants to and when he wishes.

Some therapists and social workers, such as Otto Rank and Jessie Taft, have experimented with time limits. (12) They have told their patients that they will see them for a specified number of months and that they will have to try during this limited time to make such use as they can of the services offered.

Some clinical settings leave it completely up to the therapist to determine how often he will see the patient and whether he will have regularly scheduled interviews or if he will see the patient "whenever he gets around to it." Other clinics or hospitals give the therapist more or less rigid prescriptions about time. There are numberless arrangements about the emergency use of time granted in one setting and never granted another. Some use time in a flexible way while others are rigid about it. This is as true for patient as for therapists. This is not an attempt to evaluate critically these different uses of time but only to suggest that the different rules (implicit or explicit) about the use of time form a part of structure which will influence the therapeutic process in many important ways. Research may show us more definitely which ways of working with time are the most useful; but we already know that helpful treatment can be accomplished within most any kind of time arrangement. The important factor seems to be that the therapist be aware what the time commitments—or lack of them—mean to the patient and to himself and how this would have to be handled therapeutically.

The patient who understands that he will see his therapist regularly does not need to dread from hour to hour that therapy will cease. He will use the therapeutic sessions in an entirely different way from another who may be confronted any moment with the end. It is important for the patient to know what his therapist's realistic attitude about time is. Of course, not all attitudes toward time within a hospital setting are dictated. Often the use of time is largely determined by outer necessity, such as the rotation of a resident. Too often, arbitrary time rules have to be imposed regardless of the patient's specific problem. While we all would wish to go beyond arbitrariness, it is possible to work successfully, even within rather rigid imitations of time.

The use of time in its physical sense, as expressed through the reading on a watch or on the calendar, reflects psychologic attitudes toward time in which we are more interested than we are in chronometric time. Different patients experience time in different ways. One can wait; another finds it impossible to wait. Each of them handles problems of emergency, problems of waiting, problems of letting a relationship develop very differently. Many statements that patients make about time must be understood not only in terms of the calendar but also in terms of their deeper psychologic significance, as a description of part of their inner world. One patient may find that the week end between psychotherapeutic sessions is immensely long and unbearable, and may react badly to the vacation of the tehrapist, or may react with fright to the therapist's indication that therapy may need a prolonged period.

These reactions give us clues to the inner world of the patient and indicate something about the state of affairs within the psychotherapeutic situation. One patient may find the fifty minutes of a therapy hour immensely long, and may look at his watch constantly to see when he can get away from the undesirable thoughts which he cannot express. Another patient feels that the fifty minutes are flying and that he needs much more time to make himself understood.

Another topic that may be profitably discussed here is the use of the metaphor in psychotherapy. (5, 11) If an outsider, not familiar with the psychotherapeutic process and its content, were to eavesdrop on a treatment session, or were to read the recorded material, he would often feel that the material seems to be trite, nonsensical, or superficial. Instead of deep and dramatic secrets, he might hear the therapist and his patient speak for a whole session about seemingly unimportant material.

The outside observer would be as disappointed as he who listened in on a conversation between two lovers intensively involved with each other. He discovered then that the content of the exchanges between the two people was really not very interesting at all except to the participants.

The therapist and the patient use the language of everyday life to talk about the inner world of the patient. Few patients use sophisticated psychologic language. Most give only hints about their inner state of mind and when they do so, speak in metaphors and simile, rather than in precise description. The patient who one day, after months of having ignored a certain picture on the wall of the therapist, suddenly reflects on the beauty of the picture, on the "hope that radiates from it" is of course not only speaking about the picture but also gives some information about himself and comments on the psychotherapeutic situation.

Another patient who constantly complains about the food in the hospital, the rudeness of the personnel, the stupidity of the regulations, and so on, may have in mind a comment about himself and the therapist. The only way he can think of it, so to speak, is through metaphoric descriptions, through hints and remarks about situations outside of the therapy room. The therapist may find it more profitable to answer through a metaphor than to take the question of the patient in its literal sense.

The use of such a metaphor is not concise or well thought out communication on the part of the patient, but is sometimes the best way that he has to talk about himself. Often he is unaware of the meaning he puts into the metaphoric communication. In analytic schools of therapy, the metaphor may be answered by interpretation.

Another aspect of the psychotherapeutic process which one can find in almost any psychotherapeutic situation is the nature of the *secret* in psychotherapy. The first "secret" that the patient usually tells the therapist is the confession of his illness, the confession of his symptoms. He may have been withholding such a secret, and it may have taken him a long time until he can bring himself to see a therapist to discuss his difficulties. How seriously we take the "secretive" nature of psychotherapy can be seen in the agreement we all made to consider the patient's disclosures as confidential information.

There is for the patient always the problem of whom to tell the secret and whom not to tell. Some people tell secrets as quickly as they can so that the information will travel. Others withhold their "secret" even consciously. Still others withold their secrets even from themselves and bury their conflicts deep in their unconscious minds.

These different ways of handling a secret can be exemplified by the way the lover handles his secret and also finally decides to confess his love and by the way a criminal protects the secrets of his crimes refusing to confess as long as possible. Secrets are used to attract people, to be loved by people, and to make a person attract you. Secrets are used to secure one's position, to dominate, to over-power, and to protect oneself from punishment. (8)

In psychotherapy the problem of what should be "given out" and what should be withheld constantly dominates the situaiton and influences the behavior of the patient and the therapist. Each has his own way of handling secrets, and every person will handle his secrets according to his character structure; most will fluctuate from one method to another. Of people in treatment, it can be said that they are handling their secrets according to their illness.

The keeping of secrets, the withholding of information, or the giving out of information influences the behavior of the therapist. Physicians always have had the time-honored responsibility of keeping secrets, of withholding, for example, the diagnosis. The analyst who sits behind the couch and says very little is keeping his secrets, withholding what goes on in his mind while he instructs the patient to tell him everything.

If we want the patient to tell us his secrets, we must help him to come to the conflicts which are the cause of his illness. The question is how one may motivate the patient to give up his secret, what one will have to do if the patient cannot tell his secret, and finally what one does do when the patient is ready and able to give up the secret. Too often the psychotherapist, perhaps because of lack of skill or because of inner anxieties, rather than encouraging the patient and helping him to share his secrets, prevents him from doing so as if he were afraid to hear his secret. The therapist may even act like the

lover who does not want to hear the confession of love lest it create obligations for which he is not yet ready. Thus, not only is the nature of the secret itself important, but also the way in which the patient defends himself in order not to give the secret away. There are many ways for him to resist, to delay, to get away from the problem, to hide the problem from himself or from others, to forget, to withdraw, but, in spite of all, the patient is contantly driven back to the secret since his desire to get well is as strong as his wish to hold on to the illness.

This giving and this holding onto secrets seldom represents a conscious decision. Most of the time the patient in unaware that this problem exists. However, psychotherapists within authoritative settings will more often have to deal with conscious withholding of information than will those who can offer treatment to the patients, and permit them a genuine choice to accept help or withdraw.

Often a long and bitter struggle over the giving away of a secret ends up with the patient relating a bit of information which is really not very interesting; nor does it seem important. One may find then that, behind such an "unimportant" bit of information (that had to be withheld for a long time), are deeper pressures and conflicts. These are the real secrets, and they unfold themselves only after the surface secrets have been given away. The psychotherapeutic by-products of the confessional or of catharsis are, perhaps, only preliminary phases of the total treatment process.

The recovering of secret information which finally is given to the psychotherapist usually has to do with the past. Often the patient tells about early problems with parental authority, and his confessions relate really to infantile situations. Such constant referring to the past has frequently given the impression that the psychotherapeutic process really is nothing but the uncovering of the past, that the solution of the neurosis lies in discovering its genetic cause. Other schools of psychotherapy, however, feel that the key to recovery really lies in the present, and that the past counts for little. Some therapists constantly try to get the patient back to the past while other psychotherapists, equally flexible, insist that the patient talk about the present difficulties. Both of these extreme ways may work, just as any kind of structural device if handled skillfully can bring results.

Every comment about the past contains in some sense a comment about the present situation; and all comments about the present situation also contains comments about the past. Psychotherapy takes place in the present situation, but it is a characteristic of therapy (and of the present situation) that it often needs the reflection of the past relationships in order fully to understand and to master the present difficulty. The problem of the past and the present in psychotherapy does not represent a preference for different structural devices.

The last part of this paper concerns the problem of *ending* psychotherapy. (7) Just as did the beginning phase, the ending phase will bring about typical problems in the treatment situation, and will require specific skills. "Ending" to the patient (and to the psychotherapist) means separation. Think of the weaning situation in the small child, the adolescent who leaves his home; the lover who deserts his beloved. Think of divorce; think of the ending of a friendship; and finally separation through death. The problem of separation will be determined by the inner problems each person has when anticipating separation, and in enduring and mastering anxiety about it even when outwardly it seems to be so desirable and even where he seems to long for it. Young psychotherapists often overlook the importance of separation and do not realize how important it is that they learn to handle separation in a mature way.

In analytic treatment, the patient has many months time to work through the problem of separation, dissolve the transference relationship, and even then, after treatment, he will go through a phase which in many ways will remind us of mourning. In psychotherapy which is not as intense, or as prolonged as is classical analytic treatment, there are similar elements even though in different quantity.

The ending of the treatment relationship in a truly helpful way in a hospital setting is often more difficult because it may not be possible always to the ending phase or provide the time necessary for ending. The ending is then not directly related to the needs of the patient but is brought about through change of jobs, change of service, or by a sudden hospital decision which necessitate the discharge of a patient. In many cases, it is not only the patient but also the therapist who has a problem about ending. The therapist is very much in the the same situation that the mother is in who finds it hard to give up nursing her baby even though weaning is indicated. Just like the parents who cannot let the adolescent go, he may feel that his patient is not ready to leave the experience with him. He may find that the patient needs more help and that he, the therapist, is indispensable. He may have a problem about transferring the patient to another doctor, feeling not unilke a parent that nobody but himself could be of genuine assistance to the sick person.

This problem of "letting go" will then pose itself to patient and doctor alike; and only if both permit themselves to be aware or be made aware of the psychologic difficulty in ending can they permit themselves through painful separation to achieve still another step in growth and development.

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Educational Qualifications Survey

Your President has recently authorized Louis Mantovano to conduct an educational qualifications survey.

This survey will give an up-to-the-minute roster of qualified CORRECTIVE THERAPISTS. It will assist Central Office by providing accurate information which will enable placement of the right man in the right job.

Your prompt return of the questionnaires has been very gratifying. A few questionnaires have not been received. It is quite possible some of the membership did not receive one of the questionnaires. It is extremely important that this Roster of Qualifications be complete.

If you have not returned your questionnaire accurately filled out, please do so at once. If you have not received your questionnaire request one by air mail postal card from:

LOUIS MANTOVANO, 37 Clinton Ave.

Rockville Center, L. I., N. Y.

EDITORIALS

EDUCATIONAL IMPROVEMENT

A study of educational curricula of the last two decades, reveals the tremendous strides that have taken place in the building of curricula composed of minimum essentials. This is particularly true in the fields of medicine and physical education, because of the rapid advances in pure science and research.

In every discipline related to Physical Medicine and Rehabilitation, we have produced such a galaxy of increased knowledge, that we are rapidly being forced into areas of specialization.

This is a heart-warming development in the perplexing field of rehabilitation, and shows how important coordinating all activities of the ancillary medical services into an harmonious team has become.

Our social order is becoming more complex. The individual free from disease or disability, finds adjustment to this rapidly changing moral, social and economic order of his contemporary life, confusing. When disaster strikes, be it physical or mental, leaving in its wake a residual disability or handicap, the need for adequately trained personnel in all of the adjunctive therapies to cope with his rehabilitation, becomes not only obvious, but imperative.

The offering of paid traineeships in the fields enumerated in the recent release of the Public Health Service and National Institutes of Health, is more convincing evidence of the opportunities for adequately trained rehabilitation specialists.

THE WORK OF COMMITTEES

It has been said many times, that "the whole is equal to the sum of all its parts." Appointed committees are vital parts of any organization. A dynamic Association is dependent upon active committees.

The Editorial Staff has been appointed to prepare a Journal that is professionally stimulating and a record of the activities of the Association. A relatively small number of committees have been appointed by the officers of the Association. Some of these committees have "seen nothing; heard nothing; done nothing," that has come to the attention of the Editorial Staff. Others have contributed reports, plans, news items and constructive criticisms. If the "whole is equal to the sum of all its parts," it seems rather important in the building of a dynamic Association, that all of these vital parts become active.

When your work speaks for itself don't interrupt.— Henry J. Kaiser.

The President Reports

It is my pleasant duty to remind the membership of the forthcoming Sixth Annual Scientific and Clinical Session of the Association for Physical and Mental Rehabilitation, at the Hotel Schroeder, Milwaukee, Wisconsin, July 8 to 12, 1952. A record attendance is anticipated. You are urged to obtain hotel reservations as early as possible since the facilities of the hotel, while ample, are not unlimited.

The attention of all members is especially invited to the next Convention issue not only for their own information concerning details of the arrangements, but also as a courtesy to our technical exhibitors whose constant and increasing support materiallly assists in the financing of the meeting.

Members of the various committees in charge of scientific sessions and sections have been working hard to develop an outstanding program of general and special interest, including clinical demonstrations, motion pictures and television. The latest developments in the field of therapeutic and corrective exercise will be seen and heard. Make your reservations now if you have not already done so.

The meeting of the Area Representatives and Board of Officers on the first day should be of more than usual interest. Also of equal importance will be the general assembly meeting of all members. In these turbulent times many questions of paramount interest to the Corrective Therapist are arising. It is highly important that you should note the views of your duly elected Area Representatives from whom the eventual policy of the Association emerges.

Give your support to this all important annual activity of our Association which represents you and your professional interests throughout the year.

SCHOLARSHIPS IN CORRECTIVE THERAPY*

Of special interest to our student membership is the announcement recently issued by the Public Health Service, National Institutes of Health, Bethesda, Maryland, offering paid traineeships in Corrective Therapy. The amount of the stipend will be based on the qualifications and needs of the trainee. The Surgeon General announces a traineeship program to provide specialized, advanced training for physicians and ancillary personel in the principles and practices of rehabilitation. Applications may be secured from: Chief, Extramural Programs, National Institute of Neurological Diseases and Blindness, Bethesda, 14, Maryland.

Leo Berner

* Refer to "News and Comments" Page 24

Chapter Activities

Editor's Note: Send all reports of Chapter Activities for publication in this column, to Harold M. Robinson, 3411 Birch Lawn Avenue, Roanoke, Va. Send copies of Chapter News Letters to the editor.

NEW CHAPTERS FORMED

Two new chapters of the Association for Physical and Mental Rehabilitation have been formed. The Kansas State Chapter was organized on November 1, 1951, at a meeting held in the VA Center, Wadsworth, Kansas. The following officers were elected: President, Joseph Phillips, VA Center, Wadsworth, Kansas; Vice-President, Robert Swenge, Winter VAH, Topeka, Kansas; Secretary-Treasurer, James Watkins, Winter VAH, Topeka, Kansas.

The Arkansas-Oklahoma Chapter was formed at a meeting held at the VAH, Muskogee, Oklahoma, on January 27, 1952. At that time the following officers were elected: President, Lewis Scholl, VAH North Little Rock, Arkansas; Vice-President, Troy Scholl, VAH Muskogee, Oklahoma and Secretary-Treasurer, Wayne Schwartzwalder, VAH Little Rock, Arkansas.

THE MIDDLE ATLANTIC CHAPTER

The Sixth Meeting of the Middle Atlantic Chapter was held on January 26, at VAH, Ft. Howard, Maryland. Dr. W. L. Fleck, Manager of the hospital, expressed his confidence in Corrective Therapy. A most likeable personality, Dr. Fleck started the meeting in a highly professional but informal manner.

Walter W. Stude, Administrative Assistant, Radioisotope Unit, VAH Fort Howard, Maryland, gave an interesting and stimulating lecture on "Introduction to Radioactivity." By demonstrating one of the machines used at Fort Howard, Mr. Stude illustrated to the assembly the value of the machine in diagnosis and treatment. The use of isotopes will apparently enable faster diagnosis, better treatment and thus earlier rehabilitation procedures for those related in ony way to the field of Medicine.

"The Preservation, Development and Mechanical Correction of the Quadriceps" was the topic of discussion of Dr. Louis N. Rudin, Chief, Physical Medicine at Fort Howard. Dr. Rudin, through the use of charts, drawings and other visual aids, which showed the composition and structure of the quadriceps. He also gave demonstrations on various methods of strengthening the quadriceps without the use of equipment. He finished his lecture with the showing of an ingenious device which has been developed in his division and which eliminates the locking device on single leg braces for hemiplegias. A paper relating to this subject will be published shortly.

Two members of the Association and the Middle Atlantic Chapter, Mr. Steven Castura and Mr. David Bilowitt, Kabat-Kaiser Institute in Washington, D. C., gave a practical demonstration on "Methods and Techniques Employed in Treatment of Paralytics." Going through each phase of the treatment, they demonstrated, by segment, the use of active exercise in caring for paralyzsd muscle tissue. The demonstration was on a most informal basis, thus allowing for discussion from the floor and explanation from the platform. It appears that this type of presentation is very stimulating. It promotes attendance to meetings, stimulates group discussion and encourages a great deal of thought among the assembly which carries over after the meeting has been held.

NEW ENGLAND CHAPTER

The first spring meeting of the New England Chapter, Association for Physical and Mental Rehabilitation, featured a seminar on spinal cord injuries. The meeting and clinical session was held March 29, 1952, in the Dowling Ampitheatre, Boston City Hospital. During the morning session Dr. Fritz Friedland, Chief, PMRS, Cushing VAH, discussed PMR for patients with spinal cord injuries. Dr. Herbert Talbot, Chief Paraplegic Service, Cushing VAH, spoke on the subject: Urological Consideration in Paraplegia. The morning session was concluded with a demonstration of bed exercises and self-care activities. The afternoon session opened with the presentation of an Honorary Membership in the Association to Dr. Jacob Rudd, for his contributions to the Association in which he serves as a member of the Advisory Board. Following the presentation, Dr. Donald Munro, Neurosurgeon in Chief, Boston City Hospital, spoke on surgical procedures following spinal cord injuries. A short discussion and exhibit of various types of braces used by paraplegics preceded a demonstration of mat and wheel chair activities and all crutch ambulation techniques and activities.

MIDWEST CHAPTER

At the last chapter meeting, it was decided that the following meeting for the chapter be held at VAC, Wood, Wisc., on May 31, 1952. Tentative planning is now underway for this meeting. Dr. Ray Piaskoski, Chief of PMR has offered to act as chairman on a panel discussion entitled, "Rehabilitation of the Hemiplegia." Any suggestions the membership may have will be gratefully received. *Tentative Program*: Business Meetings, 10:00-12:00; Lunch, 12:00-1:30; Panel Discussion, 1:30-3:30; Informal tour of the C. T. Dept., 3:30-on. For this meeting we are considering a joint clinical session between the Midwest Chapter of the Association for Physical and Mental Rehabilitation and the Wisconsin Association of Rehabilitation Therapists.

Book Reviews

"HEMIPLEGIA AND REHABILITATION"

HOWARD A. RUSK, M.D. in collaboration with GEORGE G. DEAVER, M.D., DONALD A. COVALT, M.D., MORTON MARKS, M.D., JOSEPH BENTON, M.D. and MRS. MARTHA TURNBLOM.

(Note—Copies of this monograph may be secured from—The Institute of Physical Medicine and Rehabilitation, New York University—Bellevue Medical Center, 400 E. 34th St., N. Y. 16, N. Y. or Sharpe and Dohme, West Point, Penna)

In this comprehensive monograph—by leaders in the field of rehabilitation—a challenging statement of the increasing problem, facing the medical profession and rehabilitation specialists, in careing for the estimated 1,000,000 hemiplegic patients in the United States today.

An excellent summary of the clinical aspects of the acute phase of hemiplegia is presented in the following topics; Etiology, Pathogenesis, Symptoms and Signs, Differential Diagnosis Prognosis and Treatment of the acute phase.

This is followed by a section devoted to—"The Treatment of Residual Defects." "In the opening paragraph the authors state, "Unfortunately in the past, the medical attitude toward hemiplegia has been one of hopeless and passive acceptance." and to the rehabilitation specialist, the fact that—"recent spot checks—have shown that 90% of all hemiplegics can be taught ambulation, self care—and 30%, to do gainful work;" should encourage rehabilitation workers everywhere, to continue making their contribution to this effort with renewed enthusiasm.

Two pages of evaluation charts are included, showing the importance of selecting patients for whom rehabilitation is feasible. Rehabilitation objectives are discussed and the methods in use to prevent deformities are indicated. Early ambulation is urged and photographs of typical cases and the exercises of most value are prescribed.

A summary of the treatment of Aphasia and a Bibliography followed by "Helpful Hints For Hemiplegics" after discharge from the hospital, makes this monograph not only helpful to the therapist, but instructive to all who are concerned with the medical care and rehabilitation of one of our most challenging neurological disabilities. EMS

SKILL AND AGE

A. T. WELFORD, An Experimental Approach, London: Oxford University Press, 1951. 8s6d. 161 pp.

It is generally recognized that the increasing age level of the U. S. population in general and of V. A. hospitals in particular will inevitably result in a steadily increasing emphasis on the role of geriatrics in Corrective Therapy programs. Those concerned with the development of Corrective Therapy must plan now for conditions which will exist in the not-too-distant future. For them books such as this will be important.

Wolford and his collaborators regard ageing as a continuous process and are as interested in discovering what older people do better as they are in finding what they do worse. An introductory chapter, "On the Nature of Skill," is an excellent presentation of the subject. This is followed by reports of research on manipulatory and mental skills. In general the findings indicate that changes in performance associated with age are located in the central mechanism of the brain concerned with the organization of incoming data and out-going action rather than in any deterioration of sense organs or muscles.

With true scientific caution the researchers are hesitant about drawing definite conclusions from their studies to date. Nevertheless, the material presented strongly suggests certain practical assumptions. The Corrective Therapist dealing with older individuals will probably find that they are comparatively slow to learn new skills, that they perform less well in activities requiring speed than they do in ones in which the premium is on accuracy, that many of them can safely participate in fairly severe exercise, and that they are happiest when working in small groups of persons of their own age.

All together, the report is a worthwhile contribution to the study of aging. PJR

RESEARCHES ON THE MEASUREMENT OF HUMAN PERFORMANCE

N. H. MACKWORTH, Medical Research Council Special Report Series No. 268. London: His Majesty's Stationery Office, 1950. 156 pp. 4s.

Early in World War II experience with radar and Asdic operators made it evident that very little was known about visual and auditory vigilance and the effects of environmental stress on men under actual working conditions. The first half of this report discusses in detail the effects of duration, knowledge of results, encouragement, benzedrine and temperature upon visual and auditory response. Several pages are devoted to a study of the conditioned factors which seem to underlie the findings. The second half deals with the effect of tear gas, toxic smoke and high atmospheric temperature on human performance, followed by a discussion of the reasons for the given findings.

Mackworth has done an excellent job of conducting and reporting what must have been long and tedious researches. No one interested in such studies or planning research in related fields can afford to be without this booklet. PJR

ANNUAL REPORT OF THE ADMINISTRATION OF VETERANS AFFAIRS....

By CARL R. GRAY, JR., Administrator of Veterans Affairs, Superintendent of Documents, Government Printing Office, Washington 25, D. C. 1951 pp 38-45

This comprehensive report presents an account of the activities and problems involved in administering to the varied needs of the 18,813,000 veterans and dependents of desceased veterans, at a cost $5,937,-501,085. It states that 151 hospitals were in operation at the close of the fiscal year of 1951. Eighteen (18) of these facilities served the tubercular patients; thirty-four (34) were for the neuropsychiatric and ninety-nine (99) for the general medical and surgical cases.

Despite shortages of personnel and materials seventeen (17) new hospitals were added during the year. Twenty-three (23) more are expected to be completed in 1952, making a total of one hundred seventy-four (174) hospitals supplying 131,000 beds, by 1953.

Canteen Service, compensation and pensions, automobiles and other conveyances, vocational rehabilitation training, life insurance, guaranteed and insured loans for home construction, grants for specially adapted housing for the disabled, indicate the wide range of activities that are needed to care for this group of our citizens.

The report devotes a full page to a statement of the changes taking place in paraplegic affairs, as the result of the increase in the paraplegic load, due to the Korean Conflict:

A coordinator of paraplegic affairs, to: "(1) establish and insure the maintenance of minimum professional standards in all paraplegic activities, and (2) coordinate the activities of all medical officers concerned with the care of the 1665 paraplegic patients in VA Hospitals," indicates the continuous effort being made to furnish adequate care for this severely disabled group.

Five pages of the report are devoted to Physical Medicine and Rehabilitation. On page 41 we read: "The function of Corrective Therapy is to afford physical measures in the form of exercise and activity, to the veteran-patient as part of his total rehabilitation. Retention and recruitment of corrective therapy personnel during the fiscal year 1951 were successful, even though a requirement of clinical practice, as well as specialized collegiate training, went into effect during that period. An increasing number of colleges and universities have made provisions for students of physical education to obtain, both at the undergraduate and graduate level, courses which include clinical practice for the application of adapted physical education in rehabilitation. These provisions have greatly benefited corrective therapy by providing students with training more closely correlated with medical treatment and thereby have made available for recruitment, personnel better qualified to meet the treatment needs of the veteran-patient."

Quoting again from page 41: "The development of the eclectic psychiatric approach to the chronic catatonic patient, initiated five years ago by the VA Hospital, Danville, Illinois, has continued in VA Hospitals." In the next few paragraphs a report of the treatment-demonstration clinic results obtained at VA Hospital, Roanoke, Virginia is made, showing that "three of the eight patients initially treated have been discharged on trial visits and four have shown some improvement."

A controlled study of the resocialization of 49 neuropsychiatric patients at Perry Point, Md., shows that there was a "a 67% reduction in the number of tubs and packs required." Eighteen (18) Neuropsychiatric hospitals reported similar reductions of packs and tubs from this treatment.

A VA film "Activity for Schizophrenia, A Corrective Therapy Technique" was selected by the A.M.A. and the American Psychiatric Association for the national meeting and televised over the CBS network.

A manual describing technical procedures involved in treating the apparently deteriorated schizophrenic of the catonic type has been prepared and 15 professional articles have been sumbitted by corrective therapists during the past year.

This report continues to give brief summaries of the accomplishments of the other four adjunctive therapies showing the importance being attached to these auxillary services to the fields of medicine and surgery. EMS

CORRECTIVE THERAPY EMBLEMS

Order Corrective Therapy emblems from Lewis Scholl, Chief, Corrective Therapy, V.A. Hospital, Little Rock, Arkansas.

The cost at present is thirty-five cents each, plus postage. Emblems will not be sent unless cash accompanies order.

A recent directive gives official recognition to emblem and states that it shall be worn two (2) inches below left shoulder seam.

The emblem identifies the wearer as one of the ancillary therapists in the Physical Medicine Rehabilitation Service.

News and Comments

FROM WASHINGTON

Eligibles who have previously filed in the examination for Exercise Therapist, GS-5, Announcement No. 299, and have not indicated that they would be willing to accept employment in the locations covered by the above vacancies should immediately notify the Central Board of U. S. Civil Service Examiners by letter, indicating choice or preferance of the location or locations they would accept employment.

Mr. Kjell Peterson, Consultant to Corrective Therapy Section, PMR, Central Office. Pete is assisting the C. T. staff in the preparation of a booklet on ambulation. With Tom Zwierlein, who has had considerable experience in this field, a plan for the organization and presentation of this important subject was laid out. Pete is a natural in this field, his "Whats My Score" having won both national and international recognition as a most helpful aid in the retraining of the severly handicapped. Over twenty thousand copies of this booklet have been distributed to doctors, therapists, nurses and others in the medical field.

The formal opening of the clinical affiliation for graduate students in Physical Education of Columbia University and the Corrective Therapy Section of the Bronx, New York Hospital was held Jan. 16, 1952. Dr. Josephine Rathbone, Assoc. Prof. Phy. Ed., introduced Dr. Arthur Abramson and Dr. John Eisele Davis who discussed the general and specific field of Corrective Therapy, the purpose and content of the course of instruction, the advantages of this clinical application and the opportunities in this growing field. Mr. Berner was introduced to the student body as the individual who will coordinate the clinical work in the hospital. The film "Activity for Schizophrenia" was shown, after which a most enjoyable social hour was held giving the students an opportunity to discuss employment opportunities in the Veterans Administration.

John J. Selwood, Asst. Supervisor, Dept. of Phy. Ed., University of California, after five weeks in a VA hospital, has been discharged and is now completing his study relating to physical education and recreation in rehabilitation. Mr. Selwood is doing a most comprehensive evaluation which should be of great value to the field.

George Reichle, program chairman for the National Meeting at Milwaukee, along with Les Root, Chief C. T. at Wood, Wis., were met in Washington on Feb. 15th by Leo Berner and Lou Montovano to discuss with Central Office Officials the first draft of the convention program. Two days of intensive work pouring over the program kept the group more than busy. Reichle and his committee are doing a superb job and the convention will undoubtedly prove to be a real contribution to therapy and rehabilitation.

Be sure to read the 1951 Annual Report of The Administration of Veterans Affairs. Beginning on page 29, the report on Physical Medicine Rehabilitation, gives a most comprehensive resume of the activities of this service. The function of Corrective Therapy and the significant advances of this Section are explained. The five sections of PMR are treated in line with their contributions during the year, 1951.

Dr. and Mrs. Peter Karpovich were recent visitors to Washington giving opportunity to Dr. Knudson and others in the PMR Service for discussing problems in research in rehabilitation and the affiliation of Columbia University Dept. of Phy. Ed. and the Bronx Hospital for graduate students in Corrective Therapy. Dr. Karpovich, who has done considerable research in swimming safety and life saving methods, conferred with Red Cross officials relative to the new methods being developed in this field.

NEW CLINIC OPENS IN PROVIDENCE, R. I.

Announcements have been received of the opening of a Physical Rehabilitation and Ambulation Clinic in Providence, R. I. staffed by CT, Joseph Colello and PT, Louis Baker. Patients are treated evenings and Saturdays. These patients are accepted only on a physicians prescription and appointments can be made by contacting either of the therapists. The clinic will specialize in general rehabilitation and in the teaching of self-care and ambulation techniques. Some contacts for the employment of physically rehabilitated individuals already have been made and the clinic is working toward the goal of total rehabilitation.

Cooperative community projects such as this are making rehabilitation available to increasingly large numbers of handicapped individuals who heretofore have not had the opportunity to receive this training. With the various therapies of the Physical Medicine team working together much can be done to further increase the scope and availability of total rehabilitation. This should be the continuing objective of the individual therapist as well as of the professional associates in the field.

DR. KNUDSON—INCOMING PRESIDENT OF CONGRESS OF PHYSICAL MEDICINE

Our Chief, Dr. ABC Knudson is being congratulated for his election as the fifth incoming President of the Congress of Physical Medicine. This is a fitting tribute to a real leader in the field, to one who has continued to grow professionally and to exert a fine influence in the field of medicine generally. As an

advisor to our National Association, Dr. Knudson can always becounted upon to provide wise and mature direction and assistance.

"The Corrective Therapy Staff at Wood, Wisconsin, welcomes you to the sixth annual convention, Hotel Schroeder, Milwaukee, Wisconsin, July 8-12, 1952."

Top Row (left to right): Dominic Cuda, Robert Krebs, Richard Burkhart. Third Row (left to right): Howard Joy, Kenneth Thornton. Second Row (left to right): Edward Misiak, Arlie Hughes. Bottom Row: George Nash. Standing: (left) John Cemirys (right) Les Root.

TRAINEESHIPS IN REHABILITATION

The Federal Security Agency, Public Health Service, National Institutes of Health, Bethesda 14, Maryland have just published information concerning National Institute of Neurological Diseases and Blindness Traineeships in Rehabilitation.

General Statement: The Surgeon General of the Public Health Service has established traineeships to provide specialized, advanced training for physicians and ancillary personnel in the principles and practices of rehabilitation. The purpose of these traineeships, termed rehabilitation traineeships, is to improve the competency of the trainee so that he can develop or function as a team member in a program of dynamic therapeutics designed to bring the patient to the highest functional level of physical, psychological, and socia-economic adjustment compatible with his disability.

Professional Fields Supported for Specialized Training: Although the training of physicians in rehabilitation principles and methods is considered by this Institute to be of the highest priority, traineeships will not be confined to the field of medicine but will be extended to other professional fields most closely connected with the rehabilitation process. The fields eligible for support are listed below; stipends will be set at levels commensurate with the professional qualifications and training of the individual candidates.

1. Medical

a. Support toward the full or partial completion of a three year course of training leading to certification by the American Specialty Board of Physical Medicine and Rehabilitation will be offered.

b. Training and Orientation in Rehabilitation for other physicians.

2. Nursing, Medical Social Work, Occupational Therapy, Physical Therapy, Vocational Counseling, Psychology (Clinical or Industrial), Speech Therapy, Educational Therapy, Corrective Therapy.

Stipends: These traineeships carry stipends which will be set at levels commensurate with the professional qualifications and training of the individual candidates. Once a traineeship is awarded, stipends may not be increased because of a change in dependency status. In the event that an award is renewed, cognizance may be taken at that time of any change in dependency status during the tenure of the first award. Training stipends are paid monthly; checks will be mailed to the trainee from the Business Office, National Institutes of Health, Bethesda 14, Maryland, on approximately the seventh day of each month to cover the preceding month.

Training Institution: Traineeship tenure may be undertaken at any recognized private, state, or federal institution where an established program of training in rehabilitation is under way. It is the responsibility of the applicant to make all necessary arrangements with the institution of his choice. (See "How to Make Application" below.)

Changes of Training Institution: Changes between training institutions, either before or after the training period has started, may be made only with the consent of (1) the responsible officer of the institution with which the trainee has made arrangements for training; (2) the responsible officer of the institution to which the trainee desires to transfer; and (3) the Director of the National Institute of Neurological Diseases and Blindness.

Time of Award and Effective Beginning Date of Traineeships: Applications for National Institute of Neurological Diseases and Blindness traineeships will be considered immediately upon receipt and notification of the action taken will be forwarded to the applicant as soon as practicable. Approved traineeships may begin at any time within ten months after the

date of award to suit the convenience of the successful applicant, his sponsor, and the institution wherein his training will be undertaken.

Duration of Traineeships: These traineeships will not be awarded for less than four-month period nor for more than a twelve-month period unless exceptional circumstances can be shown meriting special consideration. The Surgeon General (a) may extend or renew an appointment and (b) may terminate an appointment before its expiration date on request of the trainee or because of unsatisfactory performance, unfitness, or inability to carry out the purpose of the traineeship.

Travel Allowances: First class transportation may be furnished trainees from their institution of residence or home to the institution selected for training. All travel must be approved by the National Institute of Neurological Diseases and Blindness before it is undertaken. Retroactive claims for travel will not be honored. No allowance will be made for return travel, travel of dependents, or for shipping charges of personal effects and/or household goods.

Vacations: Trainees may take vacations in accordance with the rules of the institutions in which they are working and with the approval of the appropriate official, but not to exceed one month each year during the tenure of the traineeships. Vacations earned but not taken during the traineeship cannot be compensated for subsequent to the termination of the traineeship appointment.

Research: Trainees will be permitted to carry on such research activities as may be approved by the proper institution official, when such activities are incidental to, will supplement and not interfere with, their regular training program.

Publicationss If publications result from work accomplished by National Institute of Neurological Diseases and Blindness trainees, it is requested that they carry a footnote acknowledgment of the traineeship award. The wording of this acknowledgment is left to the discretion of the trainee. Two reprints of each publication should be sent to the National Institute of Neurological Disease and Blindness.

Renewal of Traineeships: Where renewal of a traineeship is sought, the request for such consideration should be received no later than thirty days before the scheduled termination of the current award. This renewal request may be made by letter, which should include, or be accompanied by the trainee's report of his progress and accomplishment toward greater competency in his elected specialty. It is also necessary that the sponsor of the trainee submit separately to the National Institute of Neurological Diseases and Blindness an evaluation of the trainee including recommendations as to the advisability of renewal of the traineeship award.

Terminal Report: A terminal report of the training accomplished during the traineeship should be made by all trainees. These reports should be submitted within thirty days of the termination of the traineeship award. It is not necessary that the terminal report follow any prescribed pattern; but rather it should be a condensed narrative account by the trainee of the course of his specialized study and training and of the benefits achieve dby the trainee from the elected training.

How to Make Application: Application forms may be obtained from:

Chief, Extramural Programs
National Institute of Neurological Diseases and Blindness
Bethesda 14, Maryland

1. The application must be supported by a complete set of transcripts of college, medical, graduate, or professional school grades.

2. All physician candidates should have forwarded to us separately a statement from the Chief Medical Officer or other responsible official as to the candidate's level or activity and performance while an intern and/or a resident.

3. Nurses candidates should have forwarded to us separately a similar statement from the Superintendent of Nurses under whom their most recent training or practice has been undertaken.

4. All candidates should forward a statement from the Chief of Service or other responsible official under whom the training in rehabilitation will be undertaken, attesting to the fact that the candidate is acceptable to him and will be provided with adequate supervision and facilities for the proposed period of training.

5. The completed application form is to be sent to the above address.

MEETINGS OF PROFESSIONAL INTEREST IN 1952

May 19-21	South West Regional Vocational Rehabilitation Asso., Convention Chairman, D. W. Russell, 303 Educational Bldg., Little Rock, Arkansas.
June 23-28	The 29th Annual Conference of the American Physical Therapy Association, Bellevue-Stratford Hotel, Philadelphia.
June 26-28	Symposium on Physical Education for Women in Modern Times and annual business meeting of the Eastern Association for Physical Education of College Women, Wellesley College, Wellesley, Mass.
July 8-12	**Association for Physical and Mental Rehabilitation, Hotel Schroeder, Milwaukee, Wisconsin; Convention Chairman, George H. Reiche, V. A. Center, Wood, Wisconsin.**
August 25-29	The 30th Annual Scientific and Clinical Session of the American Congress of Physical Medicine, Roosevelt Hotel, New York City, N. Y.
Sept. 2-5	The 3rd Annual Convention of the American Association of Rehabilitation Therapists, Hotel Statler, (formerly Hotel Pennsylvania) New York City, N. Y.

TENTATIVE PROGRAM

SIXTH ANNUAL SCIENTIFIC AND CLINICAL CONFERENCE

Association for Physical and Mental Rehabilitation

Hotel Schroeder

Milwaukee, Wisconsin

July 7, 8, 9, 10, 11, 12, 1952

MONDAY—July 7

8:30 a.m.—10:00 p.m., Registration, Fourth Floor.
8:30 a.m.—10:30 a.m., Meeting of Executive Board, Room C.
10:30 a.m.—11:30 a.m., Representative Assembly Session, Room C.
11:30 a.m.— 1:00 p.m., Lunch.
1:00 p.m.— 4:30 p.m., Representatives Assembly, Room C.
7:30 p.m.—11:00 p.m., Official Reception, Blatz Brewery Auditorium.

TUESDAY—July 8

8:00 a.m.— 5:00 p.m., Registration, Fourth Floor.
8:30 a.m.— 9:00 a.m., Exhibits. Corrective Therapy Work Shop Demonstrations.

GENERAL ASSEMBLY

MORNING SESSION: Crystal Ballroom

General Chairman: Harold C. Lueth, M.D., Dean, University of Nebraska School of Medicine.

9:00 a.m.— 9:30 a.m.
Invocation: Most Reverend Moses E. Kiley, Archbishop of Milwaukee.
Welcome: Honorable Frank P. Zeidler, Mayor of Milwaukee.
Mr. D. C. Firmin, Manager, Veterans Administration Center, Wood, Wisconsin.
N. J. Wegman, M.D., President, Medical Society of Milwaukee County.
Joseph C. Griffith, M.D., President-Elect, State Medical Society of Wisconsin.

9:30 a.m.— 9:45 a.m.
Response: Mr. Leo Berner, President.

9:45 a.m.—11:30 a.m.

PANEL DISCUSSION:

Basic Concepts of Rehabilitation

"Synergetic Factors in Rehabilitation," A. B. C. Knudson, M.D., Chairman, Chief, Physical Medicine Rehabilitation Service, Veterans Administration, Washington, D. C.
"The Approach of Physiatry to Rehabilitation," John H. Aldes, M.D., Director, Rehabilitation and Physical Medicine, Cedars of Lebanon Hospital, Los Angeles, California.
"Emotional Concomitants of Rehabilitation," Jules H. Masserman, M.D., Psychiatrist, Northwestern University, School of Medicine.
"Contributions of Psychology to the Understanding of the Patient to His Treatment," J. Q. Holsopple, Ph.D., Assistant Chief, Clinical Psychology, Veterans Administration, Washington, D. C.
"Social Determinants in Rehabilitation," Miss Margaret Towne, Program Director and Medical Social Consultant, Wisconsin Association for the Disabled, Madison, Wisconsin.
"Corrective Therapy—A Doing and Feeling Process," Mr. Leon E. Edman, Field Supervisor, Area Medical Rehabilitation, Area Medical Office, Fort Snelling, St. Paul, Minnesota.

11:30 a.m.—12:00 Noon, Exhibits. Corrective Therapy Work Shop Demonstrations.

12:00 Noon—1:00 p.m., Lunch.

AFTERNOON SESSION: Crystal Ballroom

General Chairman: John F. Sheehan, M.D., Dean, School of Medicine, Loyola University.

1:00 p.m.— 2:45 p.m.

PANEL DISCUSSION:

Psychological Theory and Technique As Related to Rehabilitation.

"Necessity for Clear Communications Between Psychology and Other Disciplines and Professions Engaged in Rehabilitation," Harold Hildreth, Ph.D., Chairman, Chief, Clinical Psychology Service, Psychiatry and Neurology Division, Veterans Administration, Washington, D. C.
"Psychological Practices as Dependent Upon Psychological Theory and Research," John M. Hadley, Ph.D., Director of Graduate Study in Clinical Psycology, Purdue University.
"Requirements of Training and Competence for Psychological Participation in Rehabilitation," George A. Kelly, Ph.D., Professor of Psychology, Ohio State University, and President, American Board of Examiners in Professional Psychology.
"Specific Psychological Contributions to Varieties of Rehabilitation Processes," Leon A. Pennington, Ph.D., Chief Clinical Psychologist, Veterans Administration Hospital, Danville, Illinois.
"Some Evolving Working Relationships Between Psychology and Corrective Therapy," John Eisele Davis, Sc.D., Chief, Corrective Therapy, Veterans Admintration, Washington, D. C.

2:45 p.m.—3:15 p.m.
Exhibits, Corrective Therapy Work Shop Demonstrations.

3:15 p.m.— 5:00 p.m.

PANEL DISCUSSION:

Rehabilitation of Hospitalized Mental Patients

"Extent, Dimensions, Specifics of Problem," Daniel Blain, M.D., Chairman, Medical Director, American Psychiatric Association, Washington, D. C.
"Basic Psycho-Physiological Mechanisms Involved," Harry F. Harlow, Ph.D., Professor of Psychology, University of Wisconsin.
"The Multi-Directional Approach," Lee G. Sewall, M.D., Manager, Veterans Administration Hospital, Downey, Illinois.
"The Activity Techniques," Richmond J. Beck, M.D., Chief, Physical Medicine Rehabilitation, Veterans Administration Hospital, Lyons, New Jersey.
"Measurements of Therapeutic Results," Mr. Harold M. Robinson, Corrective Therapist, Veterans Administration Hospital, Roanoke, Virginia.

EVENING SESSION: Guests of Allen-Bradley Company, Milwaukee, Wisconsin.

6:00 p.m.— 7:30 p.m., Dinner.
7:30 p.m.— 8:00 p.m., Entertainment by the Allen-Bradley Dramatic Group.
8:00 p.m.— 9:30 p.m.

PANEL DISCUSSION:

"Employment of the Medically Handicapped," Bruno Peters, M.D., Assistant Clinical Professor of Medicine, Marquette University, and Veterans Administration consultant V.A.H.
Wood, Wisconsin.

9:30 p.m.—11:30 p.m.
Dance—The Allen-Bradley Orchestra, Refreshments. Conducted Tours Through the Medical Facilities of the Allen-Bradley Company.

WEDNESDAY—July 9

8:00 a.m.— 5:00 p.m., Registration, Fourth Floor.

8:30 a.m.— 9:00 a.m., Exhibits. Corrective Therapy Work Shop Demonstrations.

MORNING SESSION: Crystal Ballroom

General Chairman: Richard H. Young, M.D., Dean, School of Medicine, Northwestern University.

9:00 a.m.—10:40 a.m.

PANEL DISCUSSION
Current Techniques in Rehabilitation Of
Paraplegic Patients.

"The Overall Problem, with Emphasis on Increased Treatment Load Resulting from Korean Casualties," Arthur S. Abramson, M.D., Chairman, Chief, Psysical Medicine Rehabilitation and Paraplegic Services, Veterans Administration Hospital, Bronx, New York, and Assistant Clinical Professor, Physical Medicine and Rehabilitation, New York University, College of Medicine.

"Evaluation of the Patient's Treatment and Rehabilitation Potentials," Louis B. Newman, M.D., Chief, Physical Medicine Rehabilitation, Veterans Administration Hospital, Hines, Illinois, and Professor of Physical Medicine, Northwestern University, College of Medicine.

"Neuropsychiatric Factors in Rehabilitation of the Paraplegic," Francis J. Millen, M.D., Neurologist and Psychiatrist, Milwaukee, Wisconsin, and Veterans Administration Consultant, Wood, Wisconsin.

"The Prescription of Exercise and Activity," Everill W. Fowlks, M.D., Chief, Physical Medicine Rehabilitation, Veterans Administration Hospital, Portland, Oregon.

10:40 a.m.—11:00 a.m.

"Corrective Therapy Demonstration—Ambulation Activities for the Paraplegic Patient," Mr. Frank S. Deyoe, Jr., Assistant Chief, Corrective Therapy, Cushing Veterans Administration Hospital, Framingham, Massachusetts.

11:00 a.m.—11:30 a.m.

PANEL DISCUSSION:

Rehabilitation of the Speech Impaired

"Rehabilitation Problems as Found in the University Speech Clinic," Wendell Johnson, Ph.D., Chairman, Director, Speech Clinic, and Chairman, Council on Speech Pathology and Audiology, University of Iowa.

"Speech Re-Education of Aphasics in Veterans Administration Hospitals," Hildred Schuell, Ph.D., Chief Aphasic Center, Veterans Administration Hospital, Minneapolis, Minnesota, and Associate Member, Graduate Faculty, Division of Neurology, University of Minnesota.

11:30 a.m.—12:00 Noon, Exhibits. Corrective Therapy Work Shop Demonstrations.

12:00 Noon—1:00 p.m., Lunch.

AFTERNOON SESSION: Crystal Ballroom

General Chairman: John S. Hirschboeck, M.D., Dean, School of Medicine, Marquette University.

1:00 p.m.— 2:30 p.m.

PANEL DISCUSSION

Today's Approach to the Care and Treatment Of
The Geriatric Patient.

"The Problem of the Aged and Aging in the United States," Miss Helen Manning, Chairman, Consultant on Social Services, Illinois Public Aid Commission, Chicago, Illinois.

"Psychiatric Aspects of Geriatric Rehabilitation," Morris Grayson, M.D., Chief Psychiatrist, Institute of Physical Medicine and Rehabilitation, Bellevue Medical Center, New York City.

"Neurological Problems of the Aged," H. A. Kildee, M.D., Chief, Department of Neurology, Veterans Administration, Washington, D. C.

"The Corrective Therapy Program in Domiciliary Units of the Veterans Administration," Robert V. Miller, M.D., Chief, Physical Medicine Rehabilitation, Veterans Administration Center, Los Angeles, California.

2:30 p.m.— 3:00 p.m., Exhibits. Corrective Therapy Work Shop Demonstrations.

3:00 p.m.— 3:30 p.m.

"The Physiatrist in a Civilian Rehabilitation Program," Ben L. Boynton, M.D., Professor of Medicine, Baylor University, College of Medicine, and Chief, Physical Medicine Rehabilitation, Veterans Administration Hospital, Houston, Texas.

3:30 p.m.— 3:45 p.m.

"The Corrective Therapist in a Civilian Rehabilitation Program," Mr. Jack Tracktir, Corrective Therapist, Department of Neuro-Psychiatry, Baylor University College of Medicine, Houston, Texas.

3:45 p.m.— 5:00 p.m.

PANEL DISCUSSION:

Teamwork on a Rehabilitation Ward

Introduction, Ray Piaskoski, M.D., Chairman, Professor and Director, Department of Physical Medicine and Rehabilitation, Marquette University, School of Medicine, and Chief, Physical Medicine Rehabilitation, Veterans Administration Center, Wood, Wisconsin.
Case Presentation, Carl M. Akwa, M.D., Resident Physician, Physical Medical Rehabilitation Service, Veterans Administration Center, Wood, Wisconsin.

"Neurological Consultation," B. S. Schaeffer, M.D., Neuropsychiatric Service, Veterans Administration Center, Wood, Wisconsin.

"Rehabilitation Consultation," Edwin C. Welsh, M.D., Assistant Chief, Physical Medicine Rehabilitation, Veterans Administration Center, Wood, Wisconsin.

"Social Service Report," Mrs. Beatrice W. Martin, Chief, Social Service, Veterans Administration Center, Wood, Wisconsin.

"Vocational Guidance Report," Mr. Desmond D. O'Connell, Chief, Vocational Guidance, Veterans Administration Center, Wood, Wisconsin.

"The Psychologist," S. H. Friedman, Ph.D., Chief Psychologist, Veterans Administration Center, Wood, Wisconsin.

"The Ward Nurse," Miss Barbara Benn, Rehabilitation Ward Nurse, Veterans Administration Center, Wood, Wisconsin.

"Physical Therapy," Miss Elizabeth M. Wiegert, Physical Therapist, Veterans Administration Center, Wood, Wisconsin.

"Corrective Therapy," Mr. Leslie M. Root, Chief, Corrective Therapy, Veterans Administration Center, Wood, Wisconsin.

"Occupational Therapy," Miss Nancy F. Brown, Chief, Occupational Therapy, Veterans Administration Center, Wood, Wisconsin.

"Speech Therapy," Mr. George C. Vander Beke, Speech Therapist, Veterans Administration Center, Wood, Wisconsin.

"Educational Therapy," Mr. Edward M. Sanford, Acting Chief, Educational Therapy, Veterans Administration Center, Wood, Wisconsin.

"Manual Arts Therapy," Mr. LeRoy R. Leifer, Chief, Manual Arts Therapy, Veterans Administration Center, Wood, Wisconsin.

"Follow-up After Discharge," Mr. Alfred Meier, Wisconsin State Rehabilitation Service.

7:00 p.m.— 9:00 p.m., General Assembly and Election of Officers, Crystal Ballroom.

Meetings: Chiefs of Physical Medicine and Rehabilitation and Executive Assistants, Brown Bottle, Schlitz Brewery.

Occupational Therapists, Room B.
Physical Therapists, Room C.
Educational Therapists, Room D.
Manual Arts Therapists, Room E.

THURSDAY—July 10

7:30 a.m.— 8:30 a.m., Past Presidents' Breakfast.

8:00 a.m.— 5:00 p.m., Registration, Fourth Floor.

8:30 a.m.— 9:00 a.m., Exhibits. Corrective Therapy Work Shop Demonstrations.

MORNING SESSION: Crystal Ballroom

General Chairman: Lowell T. Coggeshall, M.D., Dean, School of Medicine, University of Chicago.

9:00 a.m.—10:30 a.m.

PANEL DISCUSSION:

Educational Standards for Rehabilitation Personnel

"The Need for Ancillary Medical Personnel," Ben Boynton, M.D., Chairman, Professor, Physical Medicine, Baylor University, College of Medicine, and Chief, Physical Medicine Rehabilitation, Veterans Administration Hospital, Houston, Texas.

"The Overall Problem in the United States," Harvey E. Billig, Jr., M.D., Medical Director, The Billig Clinic, Los Angeles, California.

"Current Curricula Revisions in Schools of Physical Education," H. Harrison Clarke, Ph.D., Director, Graduate Studies, Springfield College, Springfield, Massachusetts.

"Civil Service Classification Standards for Corrective Therapists," Mr. Ralph F. Webster, Chief, Field Classification Service, Veterans Administration, Washington, D. C .

10:30 a.m.—11:00 a.m.

"The Corrective Therapist Looks to Present Educational Facilities," Mr. Arthur D. Tauber, Supervisor, Corrective Therapy, Veterans Administration Hospital, Bronx, New York.

11:00 a.m.—11:30 a.m.

"Duties of the Executive Assistant, Physical Medicine Rehabilitation," Mr. Joseph H. Van Schoick, Executive Assistant, Physical Medicine Rehabilitation, Veterans Administration, Washington, D. C.

11:30 a.m.—12 Noon, Exhibits. Corrective Therapy Work Shop Demonstrations.

12:00 Noon—1:00 p.m., Lunch.

AFTERNOON SESSION: Crystal Ballroom

General Chairman: John D. Van Nuys, M.D., Dean, School of Medicine, University of Indiana.

1:00 p.m.— 2:30 p.m.

PANEL DISCUSSION:

New Horizons of Corrective Therapy

"The Total Approach in Educating Our Physically Handicapped Youth," J. L. Rudd, M.D., Chairman, Medical Rehabilitation Commission, Massachusetts Department of Industrial Accidents, and Chief, Physical Medicine Rehabilitation, Veterans Administration Hospital, West Roxbury, Massachusetts.

"Application of Corrective Therapy to the Cerebral Palsied Child," Mr. Walter D. Matheny, Director, The Walter D. Matheny School, Incorporated, Far Hills, New Jersey.

"Corrective Exercises for the Public School Child," Mrs. Eleanor B. Stor , Instructor in Education, New York University, and Instructor, Health Education, Seward Park High School, New York City.

"Corrective Exercises for the High School Student," Mr. John C. Foti, Athletic Director, Rufus King High School, Milwaukee, Wisconsin.

"The College and University Student—A Corrective Therapy Demonstration," Mr. Robert Shelton, Associate Professor, Department of Physical Education, University of Illinois.

2:30 p.m.— 3:00 p.m.

"Research in Corrective Therapy," Reuben J. Margolin, Ed.D., Bedford Veterans Administration Hospital, Bedford, Massachusetts.

3:00 p.m.— 3:30 p.m., Exhibits. Corrective Therapy Work Shop Demonstrations.

3:30 p.m.— 4:15 p.m.

"Physical Reconditioning in the Army Medical Service," Lt. Col. Edward F. Quinn, Jr., Chief, Physical Reconditioning Branch, Physical Medicine Consultants Division, Office of The Surgeon General, Department of the Army.

5:14 p.m.— 5:00 p.m.

"Physical Medicine as a Laboratory," Mr. T. O. Kraabel, National Director, The American Legion, Washington, D. C.

7:00 p.m.—Convention Banquet, Crystal Ballroom.
Toastmaster: Arthur S. Abramson, M.D.

FRIDAY—July 11

8:00 a.m.— 5:00 p.m., Registration, Fourth Floor.

8:30 a.m.— 9:00 a.m., Exhibits. Corrective Therapy Work Shop Demonstrations.

MORNING SESSION: Crystal Ballroom

General Chairman: A. C. Furstenberg, M.D., Dean, School of Medicine, University of Michigan.

PANEL DISCUSSION:

Rehabilitation of the Amputee

"The Role of the Physiatrist," Harry H. Samberg, M.D., Chairman, Chief, Physical Medicine Rehabilitation, Veterans Administration Center, Des Moines, Iowa.

"Surgical Procedures in Amputation," Felix Jansey, M.D., Senior Attending Surgeon, Wesley Memorial Hospital, Chicago, Illinois; Attending Orthopedist, Veterans Administration Hospital, Hines, Illinois, and Professor, Northwestern University, School of Medicine.

"Post-Operative Stump Care and Preparation for Fitting the Prosthesis," Altha Thomas, M.D., Denver, Colorado.

"Selecting and Fitting the Prosthesis," Mr. Earle H. Daniel, Director, Daniel Institute of Prosthetic Service and Rehabilitation, Plantation, Fort Lauderdale, Florida.

"Training in Use of the Prosthesis," Mr. William J. Zillmer, Chief, Corrective Therapy, Veterans Administration Hospital, Indianapolis, Indiana.

10:30 a.m.—11:00 a.m.

Film—"Value of the Pylon in Pre-Prosthetic Management of the Lower Extremity Amputee," Mr. Joseph J. Phillips, Chief, Corrective Therapy, Veterans Administration Center, Wadsworth, Kansas.

11:00 a.m.—11:30 a.m.

"Conditioning Exercises for Athletes," Mr. Dee Jay Archer, Trainer, Los Angeles Rams, Los Angeles, California.

11:30 a.m.—12:00 Noon, Exhibits. Corrective Therapy Work Shop Demonstrations.

12:00 Noon—1:00 p.m., Lunch.

AFTERNOON SESSION: Crystal Ballroom

General Chairman: Stanley Olson, M.D., Dean, School of Medicine, University of Illinois.

1:00 p.m.— 2:00 p.m.

PANEL DISCUSSION:
Orientation of the Blind

"Psycho-Social Adjustments Involved," James N. Greear, M.D., Chairman, Reno, Nevada.

"Corrective Therapy in Rehabilitation of the Blind," Mr. C. W. Bledsoe, Consultant for the Blind, Veterans Administration, Washington, D. C.

"Job Placement for the Blind," Richard E. Hoover, M.D., Assistant Resident, Wilmer Ophthalmological Institute, The Johns Hopkins Hospital, Baltimore, Maryland.

2:00 p.m.— 2:45 p.m.

"Prevention of Low Back Pain," Hans Kraus, M.D., Assistant Professor, Physical Medicine and Rehabilitation, New York University.

2:54 p.m.— 3:15 p.m., Exhibits. Corrective Therapy Work Shop Demonstrations.

3:15 p.m.— 5:00 p.m.

PANEL DISCUSSION:
Daily Care Activities in Medical Rehabilitation

"Economic, Social, and Emotional Problems of the Home and Bed Bound Patient," Joseph H. Gerber, M.D., Chairman, Chief, Physical Restoration Section, Office of Vocational Rehabilitation, Public Health Service, Federal Security Agency, Washington, D.C.

"Evaluation Procedures for the Home and Bed Bound Patient," Lewis Cohen, M.D., Detroit Institute of Physical Medicine and Rehabilitation, Detroit, Michigan.

"Psychological Implications of Efforts Toward Independence," Robert E. Britt, M.D., Neuropsychiatrist, St. Louis, Missouri.

"Economic Saving Attained by Rehabilitation," Mr. Walter Harnischfeger, President, Harnischfeger Corporation, Milwaukee, Wisconsin.

"Corrective Therapy Demonstration on Home Exercises and Activity Techniques," Mr. Carl Purcell, Chief, Corrective Therapy, Veterans Administration Hospital, Hines, Illinois.

8:30 p.m.—11:00 p.m., Informal Party, Pere Marquette Room.

SATURDAY—July 12

8:00 a.m.— 8:30 a.m., Registration, Fourth Floor.

8:30 a.m.— 9:00 a.m., Exhibits. Corrective Therapy Work Shop Demonstrations.

MORNING SESSION: Crystal Ballroom

General Chairman: J. Murray Kinsman, M.D., Dean, School of Medicine, University of Louisville.

9:00 a.m.—10:45 a.m.

PANEL DISCUSSION:
Employment of the Physically Handicapped

"Economic-Industrial Needs and Relationships," Mr. William P. McCahill, Chairman, Executive Secretary, The President's Committee on National Employ the Physically Handicapped Week, United States Department of Labor, Washington, D. C.

"The Role of the Industrial Physician," Paul D. Whitaker, M.D., Director, Medical Department, Allis-Chalmers Manufacturing Company, West Allis, Wisconsin.

"Legal Aspects of Employment of the Physically Handicapped": Attitude of Industry.

"Industrial Employment of the Physically Handicapped," E. A. Irvin, M.D., Medical Director, Cadillac Motor Car Division, General Motors Corporation, Detroit, Michigan.

"A More Adequate Program for the Physically Handicapped," Mr. William F. Faulkes, Former Chief, Rehabilitation Division of the State Board of Vocational and Adult Education, Madison, Wisconsin.

George M. Reichle
Convention Chairman

MEMBERS OF THE ASSOCIATION AND THEIR WIVES ATTENDING THE ANNUAL CONVENTION IN MILWAUKEE, JULY 8th to 12th, 1952, ARE INVITED TO SPEND:

Monday evening, July 7th, 1952 as guests of the BLATZ BREWING COMPANY at its auditorium, 1047 North Broadway, from 7:30 p.m. to 1:30 p.m. The auditorium is in walking distance of the HOTEL SCHROEDER. Only 250 people can be accomodated, consequentiy those desiring guest tickets are uregd to make reservations NOW, by writing Mr. Arlie J. Hughes, Corrective Therapist, VAC, Wood, Wisconsin, stating the number of reservations. Your guest tickets may be picked up at the HOTEL SCHROEDER any time before 6:30 p.m. Monday July 7th or at the main entrance to the Auditorium between 7:00 p.m. and 7:30 p.m. that evening.

Tuesday evening, July 8, 1952, as guests of the Allen-Bradley Company at its plant in Milwaukee. Transportation to and from the plant will be furnished for those needing it. The program will include a free dinner, entertainment by the Allen-Bradley dramatic group, a panel discussion on employment of the medically handicapped, dancing and refreshments, and a tour through the medical facilities of the Allen-Bradley Company. Admission to the Allen-Bradley Company that evening will be only by ticket reservations which must be made on or before Sunday, June 22, 1952, to Robert J. Krebs, Corrective Therapist, VA Center, Wood, Wisconsin. It is recommended that members of the Association and their wives attending the convention, as well as speakers on the convention program, accept this invitation from the Allen-Bradley Company.

Notice on hotel reservations for the convention will be sent to all members of the Association and the convention program speakers on or about June 1, 1952.

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Signature of Applicant_____

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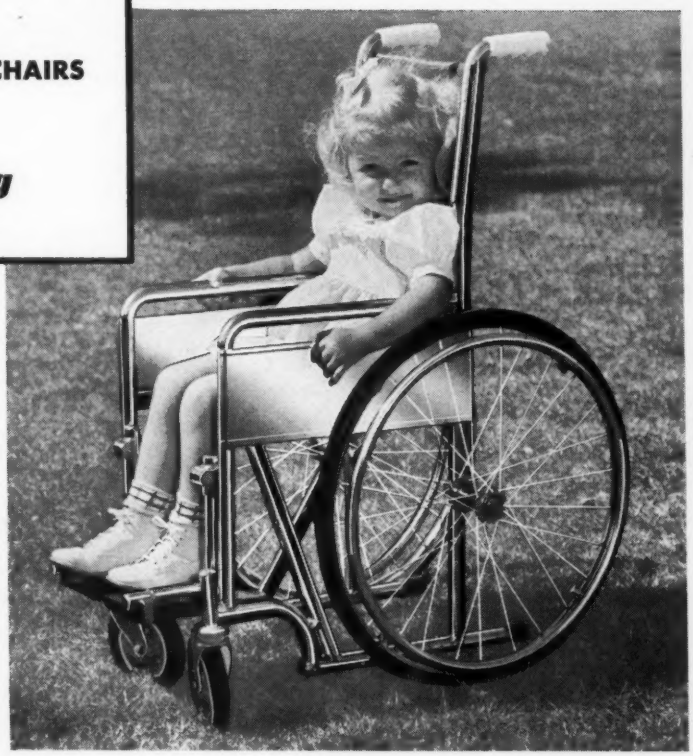

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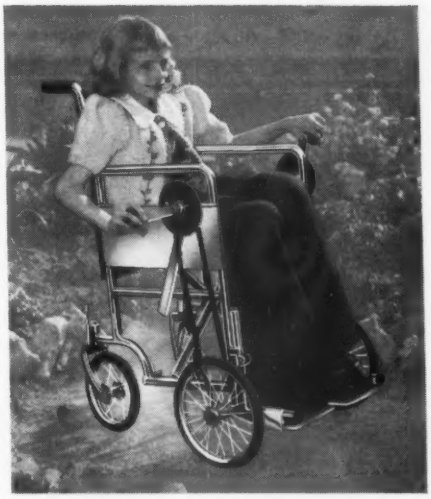

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